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ABSTRACT

A hearing was held to consider problems women face in obtaining preventive care or early comprehensive prenatal care. Testimony concerned: (1) the Public Health Service Expert Panel's report on prenatal care; (2) Los Angeles' critical shortage of maternity care providers; (3) new research from Detroit that suggests that even when prenatal care is available, women at highest risk receive the worst care; and (4) promising approaches to improving maternity care, including the March of Dimes' Campaign for Healthier Babies and a prenatal care program for employees of the First National Bank of Chicago. Fact sheets on problems and solutions related to providing care for new mothers, and numerous tables of data on care and related topics are included in the report. Also included are answers to questions posed by Representatives Bliley and Miller to James O. Mason, M.D., Assistant Secretary of the Public Health Service of the Department of Health and Human Services, concerning the President's plan to improve child health and reduce infant mortality. (RH)

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CARING FOR NEW MOTHERS: PRESSING PROBLEMS, NEW SOLUTIONS

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ED318561

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, OCTOBER 24, 1989

Printed for the use of the
Select Committee on Children, Youth, and Families

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CARING FOR NEW MOTHERS: PRESSING PROBLEMS, NEW SOLUTIONS

TUESDAY, OCTOBER 24, 1989

House of Representatives,
Select Committee on Children, Youth, and Families,
Washington, DC.

The select committee met, pursuant to call, at 9:00 a.m., in room 210, Cannon House Office Building, Hon. George Miller (chairman of the committee) presiding.

Members present: Representatives Miller, Levin, Rowland, Sikorski, Martinez, Evans, Durbin, Bliley, Wolf, Packard, Hastert, Lamar Smith of Texas, Walsh, and Machtley.

Staff present: Ann Rosewater, staff director; Jill Kagan, professional staff; Elizabeth Romero, secretary; Dennis G. Smith, minority staff director; and Carol M. Statuto, minority deputy staff director.

Chairman Miller. The select committee will come to order. The purpose of this hearing this morning is to consider problems women face in obtaining preventive care before they become pregnant and the early comprehensive prenatal care that leads to healthy babies.

Since we were established six years ago, the select committee has given high priority to the developmental and fiscal benefits of prenatal care, and the Congress has responded by expanding Medicaid to reduce financial barriers that prevent low-income women and children from receiving health services.

We have a serious infant mortality crisis in this nation, and there are signals that it is getting worse. We rank last among 21 developed nations, far behind the Surgeon General's 1990 infant mortality and low birth weight goals. Every year, 300,000 infants die or are born underdeveloped, reflecting stagnation in the infant mortality rate during the 1980s.

And in a growing number of cities, infant deaths are increasing. The District of Columbia, for instance, reported for the first 6 months of 1989 an unprecedented rate of 32.2 infant deaths per 1,000 live births, 3 times the national average. Since 1986 Baltimore, Miami, and Los Angeles also report upturns in their infant mortality rates.

The trend for low birth weight, the greatest determination of infant death and disability, is also disturbing. In 1987, the low birth weight rate rose to its highest point since 1979.

We are needlessly wasting hundreds of thousands of lives and billions of dollars a year in remedial health care, education, rehabilitation and welfare costs because of our failure to provide adequate prenatal care.

Our major challenge is to reach the more than one million pregnant women who annually receive insufficient prenatal care to prevent infant death or disability.

While financial barriers, including lack of health insurance, continue to be the most common reason for inadequate care, women confront other serious obstacles to care: services that are unfriendly or demeaning, inaccessible clinics with overworked staff, a critical shortage of private health care providers willing to accept public insurance, bureaucratic confusion, and limited child care.

Those barriers are compounded by new and complex social problems: drug abuse and sexually transmitted diseases. New York health officials recently reported that by 1995, 5 percent of all newborns in New York City will likely require costly neonatal intensive care.

In addition, in New York City alone, the number of babies born with syphilis, a potentially fatal disease directly related to rising drug use, is higher in the first 6 months of 1989 than in the entire previous year.

These issues are of special concern because new evidence gathered by the select committee from five large city hospitals suggests that pregnant substance abusers are much less likely than non-substance-abusing pregnant women to receive prenatal care.

We will hear today from members of the Public Health Service Expert Panel regarding their recently released and ground-breaking report on the Content of Prenatal Care.

Other witnesses will address Los Angeles' critical shortage of maternity care providers and new research from Detroit that suggests that, even when prenatal care is available, the highest risk women receive the worst care.

We will also learn about promising approaches to improving maternity care, including the March of Dimes' Campaign for Healthier Babies and a prenatal care program for employees of the First National Bank of Chicago.

We are reminded, however, during this 25th anniversary year of the federally initiated Maternal and Infant Care Clinics that in many cases we do not need new programs, but support for proven programs that already exist.

We are pleased to be joined as well by Assistant Secretary for Health, Dr. James Mason. I look forward to receiving all of the testimony. At this time I would like to recognize—well, here, Tom, why don't we start with you? Congressman Bliley, who has had considerable interest in this subject over the last many years in Congress.

[Opening statement of Hon. George Miller follows:]

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

CARING FOR NEW MOTHERS: PRESSING PROBLEMS, NEW SOLUTIONS

Today, the Select Committee on Children, Youth, and Families will consider problems women face in obtaining preventive care before they become pregnant, and the early comprehensive prenatal care that leads to healthy babies.

Since we were established six years ago, the Select Committee has given high priority to the developmental and fiscal benefits of prenatal care, and Congress has responded by expanding Medicaid to reduce financial barriers that prevent low-income women and children from receiving health services.

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The trend for low birthweight, the greatest determinant of infant death and disability, is also disturbing. In 1987, the low birthweight rate rose to its highest point since 1979.

We are needlessly wasting hundreds of thousands of lives and billions of dollars a year in remedial health care, education, rehabilitation and welfare costs because of our failure to provide adequate prenatal care.

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We are pleased to be joined today as well by Assistant Secretary for Health, Dr. James O. Mason.

Welcome, and I look foward to all of your testimony.

CARING FOR NEW MOTHERS:
PRESSING PROBLEMS, NEW SOLUTIONS

A FACT SHEET

INFANT MORTALITY, LOW BIRTHWEIGHT WORSENING IN U.S.

- Each year, nearly 40,000 infants die before their first birthday. In 1987, the infant mortality rate was 10.1 deaths per 1,000 live births. The black rate (17.9) was twice the rate for white infants (8.9). During this decade, progress in reducing infant deaths has slowed for both white and black populations. [General Accounting Office (GAO), 1987; National Center for Health Statistics (NCHS), 1989]

- The U.S. ranks behind 21 other industrialized nations in its infant mortality rate. (Public Health Service, 1989)

- Infant mortality rates for Baltimore, Miami, Los Angeles, and the District of Columbia have increased since 1986. The District of Columbia's infant mortality rate for the first six months of 1989 reached 32.3 deaths per 1,000 live births, a 50% increase over 1988. (Select Committee on Children, Youth, and Families Phone Survey, 1989)

- In 1987, the low birthweight (LBW) rate rose to 6.9%, the highest level since 1979. A LBW infant is 40 times more likely to die in the first month of life than normal weight infants. [NCHS, 1989; Institute of Medicine (IOM), 1985]

PRENATAL CARE LARGELY PREVENTS LBW AND COSTLY HOSPITALIZATION

- Nearly 80% of women at risk for having a LBW baby can be identified in the first prenatal visit. Infants born to women who do not receive sufficient care are about twice as likely to be of low birthweight. (Alan Guttmacher Institute, 1987)

- Every LBW birth averted by earlier or more frequent prenatal care saves $14,000-$30,000 in first-year hospital and long-term health care costs. (Office of Technology Assessment, 1988)

- Every $1 spent on prenatal care saves $3.38 in the costs of caring for LBW infants. (Select Committee on Children, Youth, and Families, 1988)

MANY PREGNANT WOMEN RECEIVE INADEQUATE OR NO PRENATAL CARE

- More than one-third of pregnant women, 1.3 million a year, receive insufficient prenatal care. (National Commission to Prevent Infant Mortality, 1988)

- One-fourth of women of reproductive age (15 million) have no insurance to cover maternity care; two-thirds of this group (10 million) have no insurance at all. (IOM, 1988)

- Each year from 1979-1987, nearly 25% of mothers did not begin prenatal care in the critical first trimester of pregnancy. (NCHS, 1989)

- In 1987, nearly 63% of surveyed Medicaid recipients and uninsured women and 69% of low-income teens received insufficient prenatal care. For the Medicaid and uninsured women, 12% of the babies were LBW. (GAO, 1987)

STRESS, FEAR, DISILLUSIONMENT WITH HEALTH CARE SYSTEM AMONG REASONS FOR NOT OBTAINING CARE

- Attitudinal barriers were cited by 39% of surveyed women who obtained inadequate care: 22% cited fear of doctors and medical exams; 10% cited fear of arrest or deportation; 10% cited cultural biases against male providers. (GAO, 1987)

- In a New York City hospital, 52% of women who had received no prenatal care cited fear of hospitals, doctors, or procedures as a primary reason for not seeking care. (IOM, 1988)

- Among 2,000 women studied in Massachusetts, women with inadequate care were significantly more likely than women with adequate care to report being very worried or upset during pregnancy due to lack of money, problems with the baby's father, housing difficulties, lack of emotional support, and related burdens. (Massachusetts Department of Public Health, 1988)

- In addition to the amount of insurance, the following factors accounted for almost half of the explanation of the differences in the amounts of prenatal care women receive: attitudes toward health professionals, delays in suspecting pregnancy, delay in telling others about the pregnancy, perception of the importance of prenatal care, and initial attitudes about being pregnant. (Poland, 1987)

FEWER HEALTH CARE PROVIDERS OFFERING MATERNITY CARE

- One fourth of U.S. zip-code areas have fewer than four obstetricians per 100,000 people, and 38 of the 577 areas have no obstetrician at all. A 1983 national survey of private physicians who provide obstetric care found that 44% did not accept Medicaid reimbursement. (IOM, 1988)

- Half of California's 58 counties had so few obstetricians who took MediCal patients that services were unavailable for 175,000 MediCal-eligible women of childbearing age. [Southern California Children's Health Network & Children's Research Institute of California (SCCHN), 1988]

- In a survey of ACOG physicians, 79% cited low reimbursement and 55% cited slow payments as deterrents to providing prenatal care to women on Medicaid. In California, the time between submission of a claim and reimbursement averages three months. (American College of Obstetricians and Gynecologists [ACOG], 1989)

MEDICAL SYSTEM'S CAPACITY, PRACTICES CONTRIBUTE TO INADEQUATE CARE

- Among 15 studies reviewed, inhospitable institutional practices and financial barriers emerged among the top five reasons for obtaining insufficient care. (IOM, 1988)

- In two studies, 60% of Los Angeles County women and 73% of New York City women with no care stated that they had tried to get care but faced a variety of obstacles. (IOM, 1988)

- In 1987, an estimated 5,000 pregnant women in San Diego and 1,850 women in Orange County were turned away from prenatal clinics. In Los Angeles County, women waited up to 16 weeks to get a prenatal care appointment. (SCCHN, 1988)

- Twenty percent of surveyed ob-gyns cited long waiting times for individual appointments as a barrier to obtaining adequate prenatal care. (ACOG, 1989)

TRANSPORTATION, CHILD CARE, LACK OF JOB FLEXIBILITY AMONG MAJOR OBSTACLES TO CARE

- Transportation difficulties were cited as a factor in preventing women from receiving adequate prenatal care by 38% of surveyed ob-gyns, 23% of interviewed women who received inadequate care, and 28% of 1,076 women surveyed by South Carolina. (ACOG, 1989; GAO, 1987; South Carolina Department of Health and Environmental Control, 1987)

- Child care was cited as factor in not obtaining sufficient prenatal care by 24% of surveyed ob-gyns and 16% of surveyed women. (ACOG, 1989; GAO, 1987)

- Inability to arrange time off from work was cited as a factor preventing women from getting adequate prenatal care by 14% of surveyed ob-gyns and 7% of surveyed women. (ACOG, 1989; GAO, 1987)

- Seventeen percent of interviewed women, including half of Hispanic women in CA who obtained inadequate prenatal care, did not know where to go to seek services. (GAO, 1987)

DRUG USE, HOMELESSNESS BECOME SERIOUS BARRIERS TO CARE

- Nearly one-third of a group of Detroit women with inadequate prenatal care abused drugs compared with 7% of women with more adequate care. (Poland, 1987)

- Of 52 surveyed women who delivered at Saint Mary's Hospital in New York City, almost half of the women receiving no prenatal care mentioned personal problems. Half of the women who cited personal problems were substance abusers. (Greater New York March of Dimes, 1988)

- Forty percent of women living in New York City hotels for the homeless who gave birth between 1982-1984 received no prenatal care. (IOM, 1988)

Mr. **Bliley**. I thank you, Mr. Chairman.

Chairman **Miller**. Do you want to catch your breath?

Mr. **Bliley**. Sorry I am late. In the aftermath of a national tragedy, Americans demand explanations and accountability. Special investigative committees are quickly assembled to tell us the cause of the accident: for example, the O-rings of Challenger, the wrong equipment supporting the Delta Force in Iran, and closed water valves at Three Mile Island.

We find some solace in finding a specific reason for the failure. Upon closer examination, we find similar patterns of miscommunication, poor coordination, conflicting demands, and emphasis on function rather than mission which contributed to each accident.

There is now some evidence that these very same traits exist in our fragmented maternal health care delivery system. In 1980, for example, the General Accounting Office found that "the fragmentation of efforts among several federal agencies administering these programs, and the lack of effective coordination among them have served as impediments to the delivery of comprehensive, high-quality services for children and pregnant women." I am sad to report that we have done very little to correct this problem.

Today, I am releasing the results of a survey of 40 counties from across the country on the "Characteristics of the Public Maternal Health Care System," which was prepared by the minority staff at my request. We asked a total of 91 providers about 8 important maternal health services which should be offered to help prevent infant mortality.

Here are some of the highlights of our findings:

Nutritional services are offered by the highest percentage of providers, 81 percent. Labor and delivery is the least available service offered, with only 7 percent providing this care. Thus, virtually every client must go to more than one provider in order to receive all needed services.

Prenatal care, perhaps the most important routine service for healthy pregnancies, is offered by just 38 percent of the service sites. More than half of public health departments offer prenatal care, but less than one-quarter of the private nonprofit organizations offer this important service.

Fifty-nine percent of the providers who refer for prenatal care reported that they did not know how long it takes for pregnant clients to begin prenatal care.

The majority of providers believe that there are obstacles to the coordination of services. Most cited reasons related to the lack of integration of services.

We also found that there are unpredictable variations in infant mortality rates among the 40 counties. The lowest infant mortality rate was found in a county that had the third highest poverty rate.

We support 10 different federal programs, which all have the same fundamental goal: to lower infant mortality. But the basic flaw that thwarts the mission lies in the design of the maternal and child health care system. A woman may have to go to one clinic for a pregnancy test, to another for prenatal care, and yet another for nutritional services.

The system is overly complex, especially for high risk clients who are least capable of negotiating their way through the bureaucratic maze of programs. It wastes the talents of qualified personnel who become frustrated by underutilization. All too often providers are shackled by bureaucratic guidelines which discourage innovation in the delivery of care. In short, the current system is designed to provide a service rather than serve a client.

We need a results-oriented approach to the problem of infant mortality. As with the tragedies I mentioned at the beginning of my remarks, Americans rightfully ask, "Who is in charge?" We must ask ourselves, "Has the complex system hidden us from accountability?"

Let us learn from past mistakes to resolve the infant mortality tragedy.

I thank you, Mr. Chairman. I apologize for being late.

[Opening statement of Hon. Thomas J. Bliley, Jr. follows:]

Opening Statement of Thomas J. Bliley, Jr., a Representative in Congress From the State of Virginia

REDUCING INFANT MORTALITY RATES: LEARNING FROM THE PAST

In the aftermath of a national tragedy, Americans demand explanations and accountability. Special investigative committees are quickly assembled to tell us the cause of the accident—for example, the O-rings of Challenger, the wrong equipment supporting the Delta Force in Iran, and closed water valves at Three Mile Island. We find some solace in finding a specific reason for the failure. Upon closer examination, we find similar patterns of miscommunication, poor coordination, conflicting demands, and emphasis on function rather than mission which contributed to each accident.

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We also found that there are unpredictable variations in infant mortality rates among the 40 counties. The lowest infant mortality rate was found in a county that had the third highest poverty rate.

We support ten different federal programs which all have the same fundamental goal—to lower infant mortality. But the basic flaw that thwarts the mission lies in the design of the maternal and child health care system. A woman may have to go to one clinic for a pregnancy test, to another for prenatal care, and yet another for nutritional services. The system is overly complex, especially for high risk clients who are least capable of negotiating their way through the bureaucratic maze of programs. It wastes the talents of qualified personnel who become frustrated by underutilization. All too often, providers are shackled by bureaucratic guidelines which discourage innovation in the delivery of care. In short, the current system is designed to provide a service rather than serve a client.

We need a results-oriented approach to the problem of infant mortality. As with the tragedies I mentioned at the beginning of my remarks, Americans rightfully ask, "who is in charge?" We must ask ourselves, "has the complex system hidden us from accountability?"

Let us learn from past mistakes to resolve the infant mortality tragedy.

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CARING FOR NEW MOTHERS: PRESSING PROBLEMS NEW SOLUTIONS

Minority Fact Sheet

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Prepared by Cathy Caridi, Liz Crnkovich & Cathy Deeds

Lack of Program Coordination

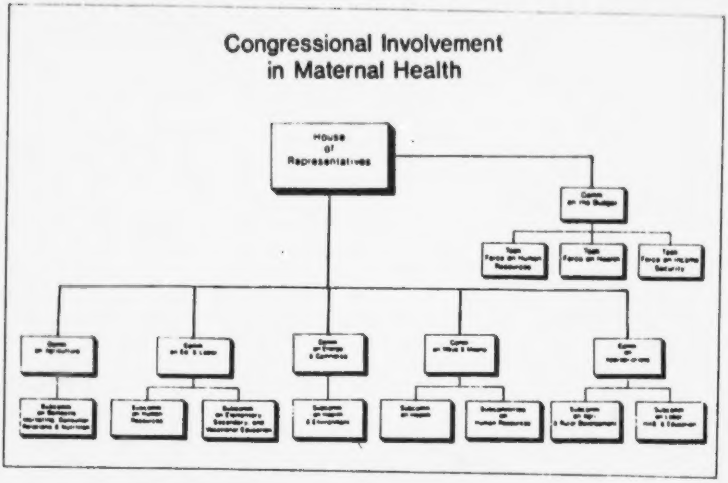
One-quarter of all women do not receive prenatal care in the first trimester of pregnancy. A closer look, however, reveals that while over 80 percent of mothers aged 25 to 39 receive prenatal care from the first trimester, only 53 percent of teenagers receive this needed care. Since teenagers account for a disproportionate share of low birthweight babies and infant deaths, we need to develop appropriate strategies to introduce them into the service system. Currently, however, there seems to be a lack of coordination among service agencies that provide this care.

o "Federal departments with Programs affecting maternal and infant Health should better coordinate their programs" -- the first recommendation for what the Federal government can do to reduce infant mortality. [Southern Regional Task Force on Infant Mortality, Final Report: For the Children of Tomorrow, November 1985.]

o "We all have to recognize that our prenatal care system -- or 'non-system' -- is a patchwork, sort of crazy quilt of programs. At the community level it is very difficult to figure out how these various pieces fit together. Any effort to improve their coordination, to simplify their relationships, to build them together is what I think over time is going to fix the problem, not incremental changes at the margin." [Sarah Brown, Prenatal Care Study Director, Institute of Medicine, National Academy of Sciences, in Infants at Risk: Is the Federal Government Assuring Prenatal Care for Poor Women?, Testimony before the Committee on Government Operations, September 30, 1987.]

o "Women must be made aware of the full array of available services as soon as they become pregnant. It would be best if pregnant women and infants could secure all necessary services at one location. At a minimum, there must be coordination of programs including Medicaid; Title V; Maternal and Child Health Programs; the Special Supplemental Food Programs for Women, Infants, and Children; Community and Migrant Health Centers; social and welfare services; mental health and mental retardation services; substance abuse; prevention and rehabilitation; special education; and family planning services." [National Commission to Prevent Infant Mortality, Death Before Life: The Tragedy of Infant Mortality, August 1988.]

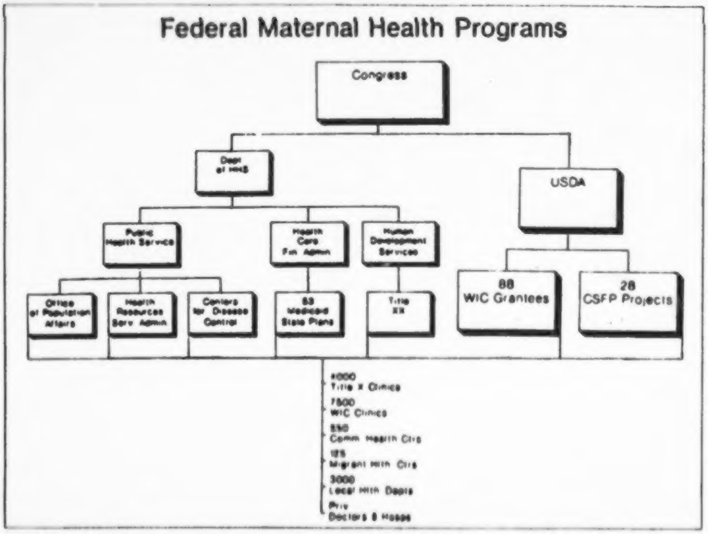
o "The Federal government, along with State and local health agencies, has a number of health care programs directed at preventing or better timing pregnancies and improving the health and well-being of mothers and infants. However, a comprehensive national strategy for using and coordinating funds and staff involved in these numerous and fragmented programs is lacking." [General Accounting Office, Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome, January 21, 1980.]



Congressional Involvement in Maternal Health

House of Representatives
Task Force on Human Resources
Task Force on Health
Task Force on Income Security

o This chart shows the complex involvement of Congressional committees in maternal health care in the U.S. This type of fragmented system includes four separate authorizing Committees, each with one or two subcommittees with jurisdiction over maternal health programs. In addition, the Committee on Appropriations, with two subcommittees, and the Committee on the Budget, with three task forces, make the major funding decisions regarding maternal health.



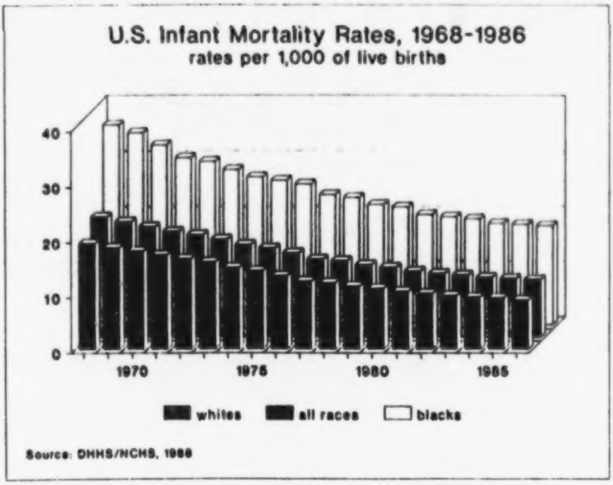
Federal Maternal Health Programs

Congress
Dept of HHS
USDA
Public Health Service
Health Care Fin Admin
Human Development Services
Office of Population Affairs
Health Resources Serv Admin
Centers for Disease Control
53 Medicaid State Plans
Title XX
88 WIC Grantees
28 CSFP Projects
4000 Title X Clinics
7500 WIC Clinics
550 Comm Health Ctrs
125 Migrant Hlth Ctrs
3000 Local Hlth Depts
Priv Doctors & Hosps

o The U. S. Department of Health and Human Services (HHS) and the U. S. Department of Agriculture (USDA) share the responsibility for administering the maternal health programs. At HHS, authority is diffused through the Public Health Service, the Health Care Financing Administration, and the Office of Human Development Services. In turn, each of these divisions enter into grants and agreements with the states and private sector providers. USDA administers 88 grants under the Special Supplemental Food Program for Women, Infants and Children (WIC) and another 28 Commodity Supplemental Food Program Projects.

There is a second layer of administration at the grantee level, which is most often performed by a state. However, there may also be another separate grantee for a specific program within a state. Thus, authority may be further divided. Finally, maternal health services are actually delivered at the local level by a variety of providers including thousands of private doctors and hospitals, 4,000 Title X clinics, 7,500 WIC sites, 550 community health centers, 3000 local health departments, and 125 migrant health centers.

This organizational chart does not include other types of programs which are only indirectly related to maternal health, but which are becoming increasingly important to healthy pregnancy outcomes. Such programs include alcohol and drug abuse prevention and control of infectious and sexually transmitted diseases, including the human immunodeficiency virus (HIV). Nor does this chart include the research component of lowering the infant mortality rate. Thus, if all programs were included, the chart would be significantly expanded.



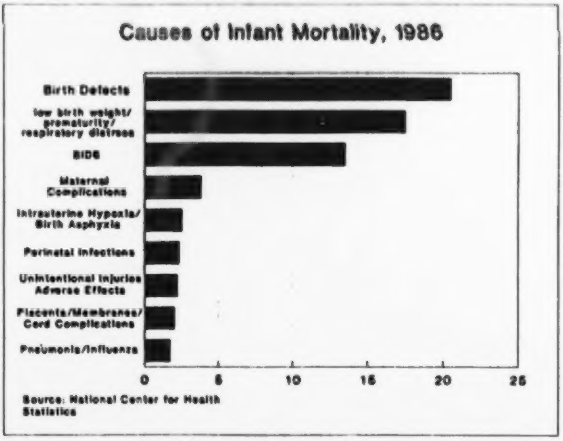
U.S. Infant Mortality Rates, 1968-1986
rates per 1,000 of live births

Source: DHHS/NCHS, 1988

o The decline of infant mortality rates in the 1970s, shown in the chart above, has been attributed largely to the invention of medical technology for the care of premature and other critically ill newborns. In the 1980s, this decline has slowed tremendously-- partly because of a lack of progress in primary prevention of conditions which lead to infant death.
(Centers for Disease Control, *Morbidity and Mortality Weekly Report*, September 22, 1989/Vol. 38/No. 37, page 635. Public Health Service, U.S. Department of Health and Human Services.)

o Important factors in further progress are: improved access to, and quality of, maternal and infant care; provision of prenatal care services in sites most frequently used by high-risk indigent women (e.g., community health centers, maternal and infant care projects, hospital outpatient department and health department clinics); and research to identify causes of perinatal loss.
(*The 1990 Health Objectives for the Nation: A Midcourse Review*, Office of Disease Prevention and Health Promotion, Public Health Service, DHHS, 1986, pg. 49)

o In 1978, the infant mortality rate for Whites was 12.0 deaths per 1,000 live births; for Blacks 23.1 per 1,000. In 1983, the rate for Whites decreased to 9.7 per 1,000; for Blacks 19.2 per 1,000. One explanation for the higher rate of Black infant deaths is that Black births are more concentrated in the high risk groups. In 1983, 25.0 percent of all Black births were to teenage mothers, compared to 12.0 percent of White births. According to the Department of Health and Human Services, Black mothers are also more likely to receive late prenatal care.
(*The 1990 Health Objectives for the Nation: A Midcourse Review*, Office of Disease Prevention and Health Promotion, Public Health Service, DHHS, 1986. Page 36-39.)



Causes of Infant Mortality, 1986

Source: National Center for Health Statistics

o This chart shows the leading causes of infant mortality with birth defects, prematurity, and sudden infant death syndrome accounting for 52% of all infant deaths. Although infant mortality has declined during the 20th century, the percentage of infant deaths resulting from birth defects has increased steadily. In 1986 birth defects were an underlying or contributing cause of death for 9093 (23.3%) infants. The federal government and 22 states maintain surveillance systems for birth defects.
(Centers for Disease Control, *Morbidity and Mortality Weekly Report*, September 22, 1989/Vol. 38/No. 37, page 633-35.)

o Sudden Infant Death Syndrome (SIDS) is the most important cause of postneonatal mortality. In 1982, the rate for SIDS was 132.2 per 100,000 live births, accounting for more than a third of postneonatal deaths.

Other factors known to have a negative impact on infant mortality include the continuing high rate of teenage pregnancy and barriers impeding access to prenatal, perinatal and infant care, particularly for high risk groups.
(*The 1990 Health Objectives for the Nation: A Midcourse Review*, Office of Disease Prevention and Health Promotion, Public Health Service, DHHS, 1986, pg. 37)

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The Challenge to Reduce Infant Mortality: Characteristics of the Public Maternal Health Care System

A Minority Staff Survey Prepared At the Request of
Congressman Thomas J. Bliley, Jr., Ranking Minority Member
Select Committee on Children, Youth, and Families

Introduction

In 1968, the United States ranked 15th in the world in its infant mortality rate. Twenty years later, despite the proliferation of public health care programs, including Medicaid, the Special Supplemental Food Program for Women, Infants and Children (WIC), and a variety of maternal and child health programs, the United States now ranks 19th in infant mortality. Although the infant mortality rate has declined to 9.9 percent, policy makers continue to be frustrated that the average annual reduction in the rate slowed during the 1980s.

The frustration turns into puzzlement when a closer look behind the statistics is taken and comparisons are made. Although Massachusetts ranked second in the nation in the overall infant mortality rate in 1986, its rate among blacks was higher than for blacks in Louisiana which ranks 44th overall. Connecticut, which has the highest personal income per capita in the nation, had a higher black infant mortality rate than Arkansas which ranks 46th in personal income per capita.

We need to understand why such differences exist if we are to make significant progress in the reduction of infant mortality rates before the end of the 20th century. We know that age is most certainly a factor in seeking important prenatal care. While over 80 percent of mothers aged 25-39 receive prenatal care in the first trimester, only 53 percent of teenagers receive this needed care. Since teenagers account for a disproportionate share of low birthweight babies and infant deaths, we must consider what barriers they face in seeking care.

A more complete understanding of the existing service system is necessary prior to the formulation of public policy in this vital health area. Thus, I asked the minority staff of the select committee to consider what barriers women face in seeking care in the public health care system.

In response to my request, the minority staff conducted a telephone survey of publicly supported health facilities across the country. A state was randomly chosen from each of the ten regions designated by the U. S. Department of Health and Human Services. Four counties in each state were randomly selected to represent urban and rural areas and the relative economic situation. Because a county may have more than one publicly-supported agency, a total of 91 service sites were surveyed.

Tom Bliley

Thomas J. Bliley, Jr.
Ranking Minority Member

Principle Findings

Characteristics

- o Simple generalities of urban vs. rural and "rich" vs. "poor" do not apply. Although the 1987 average infant mortality rate was lowest among the 10 rural counties with below average poverty rates, there appears to be only slight differences among the four types of counties (urban above poverty level, urban below poverty level, rural above poverty, rural below poverty), ranging from 8.6 percent to 9.4 percent.

- o The unpredictable variations found in the survey make national planning difficult, if not onerous. The lowest infant mortality rate was found in a county which had the third highest poverty rate among the 40 counties. Arkansas had both one of the highest and one of the lowest county infant mortality rates.

Services

Survey Responses
Services Provided

Services	% of Sites Offering Services
nutritional services and education	81%
food or food vouchers	72%
prenatal care -- including medical exam	36%
public health departments	61%
private non-profits	23%
pregnancy testing	77%
family planning	72%
obstetric care -- including labor and delivery	7%
special prenatal care for high-risk women	14%
post-partum care	48%
public health departments	68%
private non-profits	31%
formal referrals for services not offered	70%

- o Nutritional services and education is the most widely available service as they are provided by 81 percent of providers. However, just 72 percent actually provide food or food vouchers.

- o The overwhelming majority of clients are referred for labor and delivery services; only 7 percent provide obstetric care. Most clients therefore face a change in their health care provider.

- Prenatal care is offered by only 38 percent of the service sites. There is, however, a significant difference between the public and private sectors. More than half of the public health departments provide prenatal care, but less than one-fourth of the private non-profit organizations offer this important service.

- After delivery, some clients return to the publicly supported system to resume their health care. However, they find that only 45 percent of providers offer post-partum care.

Referral and Coordination

Obstacles to Coordinated Prenatal Care

Ranking	# Who Cited	Obstacle
1	18	general lack of coordination
2	14	transportation
3	12	lack of OB-GYN's
	12	inadequate resources
4	7	services difficult to access (differences in guidelines and eligibility standards)
5	6	"turf-fighting" among programs
6	4	communication among services
7	3	distance between services
8	2	caseloads too high
	2	understaffing
	2	coordination with private MD's
9	1	confidentiality of records
	1	financial problems of patients
	1	paperwork

[Note: Data is for respondents who indicated that there were obstacles to coordination]

- The majority of respondents believe that there are obstacles to the coordination of services for clients. Most cited reasons related to the lack of integration of services. It is informative to note that only 1 cited "financial problems of patients."

- While 70 percent of providers refer the client for other services, only 18 percent of the agencies offer necessary services in the same facility.

- More than two-thirds (69%) of those surveyed refer women for treatment of drug and alcohol abuse.

- Women seeking prenatal care experienced an average delay of 2.1 weeks before receiving medical care services. There was wide variance in the time-lag at different clinics: the shortest delay was one week; the longest was six weeks. These statistics are derived only from the clinics who keep this information, and therefore, could respond to the question. Fifty-nine percent of the surveyed clinics reported they did not know how long it takes for pregnant clients to begin prenatal care.

Funding

Survey Responses
Funding

Program	% of Sites Receiving Funds
Medicaid	84%
Maternal and Child Health Block Grant	54%
Social Services Block Grant	11%
Title X	47%
WIC	88%
State Appropriations	60%
Commodity Supplemental Food Program	9%
Other Funds	49%

- Of those surveyed, 88 percent received funding from more than one source. 77 percent received support from 3 or more funding sources. Multiple funding sources means that there are multiple guideline and reporting requirements as well unpredictable fluctuations in funding amounts.

- While Medicaid and WIC are the largest sources of public funding, more than half of the agencies report that they receive state appropriations and/or Maternal and Child Health Block Grant funds.

County Demographic Characteristics

State	County	Poverty Rate	% Urban	Inf. Mort. Rate
Maine:	1	16%	48%	6.9
	2	22%	12%	8.9
	3	10%	60%	6.3
	4	10%	61%	10.7
New York:	5	22%	100%	11.9
	6	17%	36%	4.9
	7	11%	88%	6.8
	8	10%	61%	6.8
Virginia:	9	20%	64%	8.1
	10	21%	34%	13.2
	11	7%	64%	5.1
	12	7%	16%	10.3
Alabama:	13	27%	88%	16.7
	14	39%	21%	12.9
	15	17%	66%	10.4
	16	16%	39%	13.6
Ohio:	17	12%	98%	8.8
	18	26%	11%	2.7
	19	6%	62%	6.8
	20	7%	18%	3.4
Arkansas:	21	20%	61%	7.2
	22	22%	3%	9.1
	23	13%	66%	12.2
	24	12%	28%	3.4
Iowa:	25	16%	73%	7.0
	26	16%	19%	4.4
	27	8%	66%	11.0
	28	8%	39%	8.6
Colorado:	29	20%	66%	10.5
	30	18%	29%	8.0
	31	8%	96%	12.1
	32	7%	38%	11.0
California:	33	15%	71%	10.5
	34	13%	46%	n/a
	35	7%	93%	7.5
	36	9%	42%	7.7
Washington:	37	15%	61%	7.0
	38	15%	16%	7.1
	39	5%	92%	9.2
	40	9%	56%	3.6

Chairman **Miller**. Congressman Rowland.

Mr. **Rowland**. Thank you, Mr. Chairman. Mr. Chairman, all too often women who need maternity care encounter barriers that prevent them from receiving this care. These barriers may be financial or bureaucratic or educational in nature.

There is a wide range of these barriers. And together they represent one of the most difficult problems we face in trying to reduce premature births and the high rate of infant mortality that we have in our country.

Mr. Chairman, I commend you for calling this hearing to give the committee an opportunity to identify these barriers and help develop programs to overcome them.

Today, Mr. Chairman, I guess I am wearing two hats: one as a member of this select committee; and the other as the Chairman of the National Commission to Prevent Infant Mortality.

The National Commission has looked into obstacles that are placed in the way of women who need early prenatal care. And information that we obtain in these hearings will be an important addition to the National Commission's work.

As those of you on the select committee know, the Commission has been advocating the expansion of home visiting programs, the implementation of a concept of one-stop shopping, and the development of a home health handbook for pregnant women and children.

These programs, which are designed to help remove many of these barriers, are included in legislation entitled "The Healthy Birth Act of 1989," which is now pending in Congress.

Home visiting programs will identify high risk populations and work with these populations to promote healthy births and infant care.

One-stop shopping programs will enable women to qualify for a variety of services under a consolidated and simplified system.

The home health handbook would inform women about prenatal and infant care and provide an ongoing record of her pregnancy and the health of her child.

I look forward to discussing these and other ideas and learning more about what we can do to lower the country's shameful infant mortality rate. Mr. Chairman, in a survey that had just been completed by the Medical Association of Georgia, in my own state, nearly one-third of the responding physicians said they had discontinued some or all OB services within the last three years.

One in five physicians in the last three years have stopped altogether delivering babies. And in South Georgia 42 percent of those responding had either cut back or stopped doing OB.

The most frequently mentioned reason for this was the ever-present and ubiquitous threat of malpractice litigation.

Mr. Chairman, this is a cancer, I believe, on pregnant women, particularly in rural areas and in inner-city urban areas that we must find a way to deal with.

Thank you, Mr. Chairman.

Chairman **Miller**. Thank you.

Mr. **Walsh**. Thank you, Mr. Chairman. I commend you for calling this hearing today on the crucial issue of infant mortality. The health and prenatal care provided for pregnant women is an issue of increasing concern.

It is my pleasure to welcome two witnesses from my district this morning, Ms. Kathy Ruscitto of Syracuse, N.Y. who serves as the Onondaga County Administrator for Human Services. Ms. Ruscitto is a Board member of the Maternity and Early Childhood Foundation.

I also welcome Dr. James Miller of Syracuse, who serves as the Commissioner of Onondaga County Health Department and President of the New York State Association of County Health Officials. I would like to thank you both for coming.

In times of limited health resources and alarming pregnancy figures, the present health care system makes it difficult for pregnant women to get the services they need. Because of this fragmented system, the number of infant mortalities is rising.

Within my district alone, the infant mortality rate is higher than other cities with comparative economic and demographic backgrounds.

We must attempt to redefine the prenatal care system and its structure. The already existing programs which affect maternal and infant health should be better coordinated and made more accessible. It is our responsibility to try and provide a better system to combat the problem of infant mortality.

I am a cosponsor of Mr. Bliley's bill to amend the Public Health Service Act. The amendment would consolidate federal programs with respect to maternal and child health.

Thank you, Mr. Chairman.

Chairman MILLER. Thank you.

Mr. MACHTLEY. Thank you, Mr. Chairman. I, too, commend you for having this hearing on a most important subject. I appreciate the opportunity to take an in-depth look at this very critical issue.

I frankly admit to being more than mystified, perhaps a little horrified, that a nation as great as ours, with so much that we spend on health care, is ranked 17th in the world in infant mortality.

Obviously, we are not targeting our available resources in the right direction. The availability and utilization of prenatal care has a direct correlation with a healthy baby. Yet, we seem to be spending billions of dollars on neonatal intensive care units. Whereas, fewer dollars spent on prenatal care would have prevented the burden of extensive hospitalization.

Dr. Roseman, Chairman of the Public Health Service Expert Panel on the Content of Prenatal Care, stated that a . . . "singularly important resource to our society is the newborn infant if born with the capacity to function well in our world. In contrast, if born already deprived, unable to function with full equality as a newborn citizen, waste and harm come to the individual and the community."

Frankly, this world is not an easy place. We must give these kids a fighting chance from the very beginning, from their first breath.

In my own State of Rhode Island, I am particularly concerned about the infant mortality rate of minorities. In 1987 the infant mortality rate for white babies was 8.1 deaths per 1,000 live births compared to 10.8 for black infants.

Barriers such as lack of knowledge, lack of transportation, inconvenient clinic hours, inadequate number of health care providers to staff clinics, language barriers, and malpractice and liability concerns particularly of OB/GYN physicians all contribute to this tragedy.

I look forward to hearing the expert testimony presented here today. I hope it will provide insight into how we got into this situation and where we should go from here.

One of the recommendations made in the August 1988 report by the National Commission to Prevent Infant Mortality was that the health and well-being of mothers and infants be given national priority by providing early coordinated care to those mothers who are at risk.

Our nation will be stronger and more competitive in the world today and tomorrow and, frankly, save money for remedial care. Thank you.

Mr. DURBIN. Thank you, Mr. Chairman. We've had hearings on this subject before under your leadership. I commend you for bringing this issue back before this Committee.

I remember after one such hearing traveling to the Midwest and listening to doctors who provide the care to pregnant mothers and children at risk telling us that they didn't have the funds, that the rates weren't adequate, that the liability insurance that they have to carry was so great that it forced them out of the business. And, thus, those limited resources that those people had to go to were dwindling.

That was two years ago. I'm interested to see today, with the witnesses and the testimony, where we are today, what is happening, and if the problem has changed at all.

And so without any further ado, I would ask that we move along. Thank you.

Chairman MILLER. Thank you.

And I thank you all for your commendations for my holding this hearing. The prime mover behind this hearing is Congressman Bliley, who has been working in this area on his other committee assignments for a considerable period of time and has asked that the Select Committee again review this continued national problem. So I want to thank him also for his participation and suggestion of these hearings.

And with that, we will welcome Dr. James Mason to the Committee. Dr. Mason, welcome to the—oh, Congressman Martinez, do you have any statement?

Mr. MARTINEZ. No, I haven't a statement.

Chairman MILLER. Okay. Thank you.

And if you'll identify the others with you, welcome to the Committee. And you proceed in the manner in which you're most comfortable.

This is usually a committee room that's reserved for the budget, so nobody gets too close in here. We can see you. We may not be able to hear you. But welcome, in any case, and we look forward to your testimony.

STATEMENT OF HON. JAMES O. MASON, M.D., ASSISTANT SECRETARY AND ACTING SURGEON GENERAL, U.S. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY DR. DUANE ALEXANDER, DIRECTOR, THE NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT; AND EAMONN McGEE, DEPUTY DIRECTOR OF THE DIVISION OF MATERNAL AND CHILD HEALTH, HEALTH RESOURCES AND SERVICES ADMINISTRATION

Dr. **Mason**. Thank you, Chairman Miller and members of the Committee. We appreciate your setting up this hearing and for our invitation to participate.

I'm accompanied by: Dr. Duane Alexander, who is on my right, who is Director of the National Institute of Child Health and Human Development; on my left, Mr. Eamonn McGee, Deputy Director of the Division of Maternal and Child Health, Health Resources and Services Administration.

Nearly four million babies are born in the United States each year. In 1988 an estimated 38,700 babies died before reaching their first birthday, resulting in a provisional national infant mortality rate of 9.9 deaths per 1,000 live births.

This is an all-time low rate, and that is a very positive development, but I have to raise a word of caution that these are national figures, averages of 50 states, and almost 3,000 communities within the nation. Within that group, there are variations, some going up and some going down.

This infant mortality rate is offset by at least five pressing concerns. First, as you have mentioned, Mr. Chairman, there are 21 other developed countries that have lower infant mortality rates than we do. Some of these are substantially lower.

Second, there are great differences among population groups within the United States. In particular, the black infant mortality rate remains twice the white rate.

And, third, the rate of improvement has slowed, and factors such as low birth weight and access to prenatal care have shown no improvement at all in recent years.

A fourth problem you have mentioned. It is the growing impact of drug abuse and related behavior on infant mortality.

And, finally, the problem of malpractice liability, which becomes a barrier or provides a chilling effect to the practice not only of obstetricians, but family practitioners particularly, in underserved areas, where services are most needed.

Our infant mortality rate is almost double the rate of Japan and some Scandinavian countries. I have said on various occasions I think we ought to be more concerned about Japan's lead over us in its ability to produce healthy babies than its ability to produce cars or electronics.

The infant mortality rate for blacks in this country is about twice the rate for whites. In 1987 the infant mortality rate for blacks was 17.9, a rate comparable with the infant mortality for whites 25 years ago.

Rates for some other minority groups, while not as dramatic as the black rate, are problematic, too. Before we even think about reading too much into the figure for whites, we should remember that a dozen countries have lower infant mortality rates than our infant mortality rate for whites alone.

The 10 leading causes of infant mortality in order of prevalence are: congenital anomalies, sudden infant death syndrome, respiratory distress syndrome, prematurity, maternal complications, hypoxia, injuries, perinatal infections, placental complications, and pneumonia and influenza.

As we try to focus attention on the likely ways to reduce the nation's infant mortality rate, we must look closely at the problem of low birth weight. In the scientific community, there is general agreement that the most critical factor in an infant's ability to survive is the infant's birth weight.

And, of course, we should remember that of those babies who do survive birth, those with a low birth weight have a much higher incidence of severely disabling conditions and at devastating emotional and financial costs.

In recent years we have not recorded any improvement in the incidence of low birth weight or very low birth weight. We know what risk factors are most frequently associated with low birth weight: behavioral factors, such as smoking, alcohol, and drug use, poor diet and nutrition.

Smoking accounts for approximately 25 percent of low birth weight and 10 percent of infant mortality. Each year about 5,000 fetal alcohol syndrome babies are born in this nation. As high as 10 percent of the mothers delivering babies in this nation are addicted to various substances.

There are biomedical factors, such as the age of the mother. Under 17 and over 35, for example, produces a risk, poor maternal health, having many children, and any untreated conditions during pregnancy, such as diabetes or infection.

There are social and environmental factors, such as poverty, stress, low educational attainment, teenage childbearing, and exposure to environmental toxins or hazards, such as lead.

Many of these factors can be identified, and they should be identified and addressed before pregnancy, in primary care, or early in pregnancy through prenatal care.

While there is no panacea or magic formula for eliminating our nation's infant mortality problem, we know from the achievements of other countries and of some of our states that if we just applied what we already know about health promotion, reduction of behavioral risk factors and access to quality primary health care, we could reduce infant mortality significantly in our country.

We estimate that we could save 10,000 of the 40,000 babies who die each year just by applying what we already know about things like one-stop shopping, case management, outreach, and home visiting. Our goal must be to have every pregnant woman involved early and continuously in prenatal care.

The savings in human and economic terms would be enormous. For example, in 1988 the National Commission to Prevent Infant Mortality estimated the hospital costs alone for low birth weight babies were in the range of $2 billion annually. The cost of providing prenatal care to those not receiving it now would be about $500 million annually.

To produce healthy children, we need to think as broadly and as expansively as we can about the medical, psychological, and social factors that contribute to that goal. It's not enough, as we once thought, for prenatal care to focus on purely medical issues of the final trimester of pregnancy. Rather, we need to expand prenatal care to the earliest stages of pregnancy. In fact, we must inaugurate care before conception.

Healthy children are not the products of skillful physicians alone. Rather, they require an extensive network of nurses, social workers, nurse-midwives, counselors, and volunteers all attuned to the mothers' cultural background, personal habits, and social environment.

Healthy children demand the mother's attention to factors ranging far beyond the medical requirements of new life within her. In fact, virtually every aspect of the mother's personal behavior, what she eats, what she drinks, her disposition to smoke or abuse drugs and, beyond that, her general morale and her grasp of essential parenting skills, bear critically on the health of her child.

Healthy children require not only caring mothers, but dutiful fathers and healthy families as well, families that are thriving psychologically as well as physically and that can provide an immediate environment of care, support, and knowledgeable attentiveness.

In short, in order to have healthy children, we must tend to far more of their immediate medical needs. We must construct around them an extensive, tightly woven, nurturing canopy of adult concern and responsibility.

Now, I know that these are long-term goals, but we must head as a nation in that direction. That must be the course that we follow. For the Bush Administration and, particularly, for Secretary Sullivan and myself, addressing the infant mortality problem has become not just a duty of office, not just the work of a doctor or a public official, but a mission to be pursued with all the resources we can muster.

As Secretary Sullivan put it, this is not just an important cause; it is going to be a crusade. That's why one of the first steps the new administration took was to send Congress a proposal to expand Medicaid coverage for pregnant women and infants.

Our proposal would raise Medicaid eligibility to 130 percent of the poverty level, require states to cut red tape by implementing a Medicaid presumptive eligibility process for women seeking prenatal care, provide Medicaid coverage for immunization of children under 6 years of age who are eligible for Food Stamps, and provide an additional $20 million in each of the next 2 fiscal years for demonstration projects that promise to increase the proportion of healthy pregnancies.

These proposals would increase by approximately 374,000 the number of pregnant women and children eligible for Medicaid. We feel that this is a broad step in the right direction.

Thank you, Mr. Chairman. We appreciate the opportunity to appear before this Committee. We'd be happy to answer any question you or members of the Committee might have for us.

Prepared Statement of James O. Mason, M.D., Assistant Secretary for Health and Acting Surgeon General, U.S. Public Health Service, Department of Health and Human Services, Washington, DC

Mr. Chairman and Members of the Committee:

I welcome the opportunity to discuss with you today the problem of infant mortality in the United States.

Over two hundred years ago our Declaration of Independence expressed Americans' inalienable rights of "Life, Liberty and the pursuit of Happiness." But a great number of our youngest citizens will scarcely have the opportunity to exercise the most basic of these rights. That's because nearly 40,000 Americans born this year will not live to see their first birthday.

Another 400,000 infants born this year will live to their first birthday but may become statistics of another kind. These unfortunate children will be born with or develop chronic conditions that are disabling enough to deprive them of true independence.

Our achievements as a Nation are known the world over. In science, technology and the arts we are world leaders. But the grim statistics just cited vividly remind us that in spite of our great accomplishments, for many of our youngest citizens, the American dream remains elusive. What makes matters worse is that we know all too well that many of the conditions which rob infants of a healthy, independent life or even of life itself, could, by proper prenatal and pediatric care, be prevented.

I'd like to share with you today what we in the Public Health Service know about infant mortality and how we are working to implement those alternatives which have the greatest potential for bringing Federal, State, local and private sector efforts to bear on the problem.

Infant Mortality Trends

Nearly four million babies are born in the United States each year. In 1988, an estimated 38,700 babies died before reaching their first birthday, resulting in a provisional infant mortality rate of 9.9 deaths per 1,000 live births. This is an all-time low rate and that's a very positive development. But it is offset by three pressing concerns.

First, there are 21 other developed countries which have lower infant mortality rates than we do, some substantially lower. Second, there are great differences among population groups within the United States; in particular, the black infant mortality rate remains twice the white rate. And third, the rate of improvement has slowed, and factors such as low birthweight and access to prenatal care have shown no improvement at all in recent years. Let's briefly consider each of these issues.

First, about our ranking among the industrialized nations of the world. Our rate is almost double the rate of Japan, currently the lowest among the industrialized countries, or the Scandinavian countries. I've said on various occasions, I think we ought to be more concerned about Japan's lead over us in its ability to produce healthy babies than its ability to produce cars or electronics.

Japan has come a long way to overtake us in infant mortality. For example, in 1960, Japan had an infant mortality rate 20 percent higher than the U.S. rate. However, in the years from 1960 to 1985, Japan reduced its rate from 30.7 to 5.5, a reduction of 82 percent. During that same time period, we were able to lower our rate from 26.0 to 10.6, a 59 percent reduction.

A second concern is the high infant mortality rates among certain groups within the United States. The infant mortality rate for blacks in this country is about twice the rates for whites. In 1987, the infant mortality rate for blacks was 17.9, a rate comparable with the infant mortality rate for whites 25 years ago. Rates for some other minority groups, while not as dramatic as the black rate, are problematic too. And, before we even think about reading too much into the figure for whites, we should remember that a dozen countries have lower infant mortality rates than our infant mortality rate for whites alone.

The third concern is that our infant mortality rates have shown a general slowdown in improvement. During the 1970's, infant mortality declined annually by 4.9 percent for whites and 4.1 percent for blacks. But in 1987, the rate of decline in infant mortality for whites was only 3.6 percent and the black infant mortality rate declined by less than one percent for the third straight year.

Leading Causes of Infant Mortality

The ten leading causes of infant mortality, in order of prevalence, are: congenital anomalies, sudden infant death syndrome (SIDS), respiratory distress syndrome, prematurity, maternal complications, hypoxia, injuries, perinatal infections, placental complications and pneumonia and influenza.

It is worth noting that the very troubling black-white disparity in infant mortality rates all but disappears when we look at the deaths from congenital anomalies. This is the only leading cause of infant death for which there is no significant black-white difference. Since congenital anomalies are related to genetic and biological factors, this suggests that social, behavioral and environmental factors account for the major part of the black-white variation.

Low Birthweight

As we try to focus attention on likely ways to reduce the Nation's infant mortality rate, we must look closely at the problem of low birthweight. In the scientific community, there is general agreement that the most critical factor in an infant's ability to survive is the infant's birthweight. Babies born at what we consider low birthweight, that is, below 2,500 grams (5 lbs., 8 ozs.) are 20 times more likely to die than those born above 2,500 grams. While there are more than 250,000 low birthweight babies born each year, only 7 percent of all live births, they account for nearly 60 percent of all infant deaths.

Babies born at what we consider very low birthweight, that is, below 1,500 grams (3 lbs., 5 ozs.), most of whom are premature deliveries, are 40 times more likely to die than those born above 2,500 grams.

And, of course, we should remember that of these babies who do survive birth most do so with much higher incidence of severely disabling conditions and at devastating emotional and financial costs.

In recent years there has been no improvement in the incidence of low birthweight or very low birthweight.

We know what risk factors are most frequently associated with low birthweight:

- There are behavioral factors such as smoking, alcohol and drug use, poor diet and nutrition.
- There are biomedical factors, such as the age of the mother (under 17 or over 35), poor maternal health, having many children, and any untreated conditions during pregnancy such as diabetes or infection.
- There are social and environmental factors such as poverty, stress, low educational attainment, teenage childbearing, and exposure to environmental toxins or hazards such as lead.

Many of these factors can be identified and addressed before pregnancy, in primary care or early on in pregnancy through prenatal care.

And, while there is no panacea or magic formula for eliminating our Nation's infant mortality problem, we know -- from the achievements of other countries and of some of our States -- that if we just applied what we already know about health promotion, reduction of behavioral risk factors, and access to quality primary health care, we could reduce infant mortality significantly. We estimate that we could save 10,000 of the 40,000 babies who die each year, just by applying what we already know about things like case management, outreach and home visiting.

The savings in human and economic terms would be enormous. For example, in 1988 the National Commission to Prevent Infant Mortality estimated the hospital costs alone for low birthweight babies were in the range of $2 billion annually.

Federal Efforts

A recently developed inventory of Federal programs related to infant mortality indicates a total of 93 Federal programs administered by 20 Federal agencies address issues related to infant mortality. These programs provide for such activities as health services, social services, training, education, health promotion, research, public assistance, drug abuse treatment and prevention, nutrition, data, and information. They represent decades of creativity and dedication by thousands of experts across the land.

Yet, as I said earlier, we can and must do better. New approaches are necessary to reduce the infant mortality rate further. To that end, you should know of an effort in process. I chair an interdepartmental Task Force, convened by the White

House that is now conducting a broad-based review of the Nation's infant mortality problem. To assure that our view is comprehensive, the Task Force has members from the Departments of Agriculture, Commerce, Defense, Education, Energy, Housing and Urban Development, Interior and Labor. We also have representatives from many of the offices within the Office of the President - ACTION, Cabinet Affairs, the Council of Economic Advisors, the Domestic Policy Council, the Office of the Physician to the President, the Office of Management and Budget and the Office of the Vice President.

The membership of the Task Force begins to suggest the range of efforts addressing infant mortality now underway within the Federal Government and the complicated and interconnected nature of this problem.

Current Activities in the Department

Within the Department of Health and Human Services, Secretary Sullivan has identified improving access to quality health care for low-income and minority pregnant women and infants as a Departmental initiative.

The thrust of the Department's existing efforts is based upon these principles:

- Access to and utilization of the full range of pregnancy and infant health services are essential if the infant mortality rate in this country is to be lowered. Prenatal care is the most effective and least costly means to good health early in life.

- A further reduction in infant mortality will require the combined efforts of the public and private sectors and of activities at the national, State, and local levels. It also requires pregnant women to seek prenatal care early, obtain good nutrition, and alter behaviors, such as smoking and abuse of alcohol and drugs, that are harmful to themselves and their fetuses.

- We must target our resources to areas of greatest need.

Our efforts are organized around removing financial barriers, enhancing service delivery, and providing better information to both consumers and providers.

Financial access to health care is important and the President has submitted a proposal which would expand the number of low-income pregnant women eligible for Medicaid. But the ability to pay for health care alone will not assure that a pregnant woman receives the care she needs. Thus, many of the Department's current efforts build upon and attempt to achieve better coordination among the extensive array of existing programs.

We are, for example, looking very carefully at several models of one-stop shopping, that is the co-location of health and various social services, which has received considerable attention in recent months. One-stop shopping is based on the premise that by allowing eligibility for AFDC, Medicaid, and other social services to be determined at the same time and at the same site that health care is delivered, there will be an increased likelihood that the poor pregnant woman will successfully "navigate" the complex and confusing system and receive the full range of services which she needs and to which she is entitled.

One pilot project at the Central Virginia Community Health Center in New Canton, Virginia (serving seven rural counties) is developing on-site Medicaid and WIC enrollment and improving record transfer between clinic and hospital. In a second pilot project, the Alabama Department of Health is working with 3 other State agencies (Human Resources, Mental Health, and Medicaid) to integrate financial eligibility requirements. Through these pilot projects and information gained from other States and a national advisory committee, we will determine the processes needed to facilitate best practices for one-stop shopping.

Home visiting, especially through the use of trained volunteers like our Resource Mothers project in South Carolina, is another approach which has shown great promise in several areas of the country in recent years. I know that Congressman Bliley is familiar with the promising results in projects serving families in the Tidewater area of Virginia, in various rural parts of Appalachia or even right here in the District of Columbia.

I can also assure you that strategies such as outreach through home visiting, information guides to pregnant women and young families such as Prenatal Care and Infant Care, the two most popular publications on the GPO list, and improving the content of prenatal care according to the suggestions made in the recently released Report of the PHS Expert Panel on the Content of Prenatal Care are among the approaches we are carefully considering. We also intend to evaluate new and existing programs to assure their effectiveness in improving infant health.

It is clear that approaches selected need local targeting. First, efforts should be directed to subpopulation groups contributing most to the high infant mortality rates - in other words, those pregnant women and infants most in need in local communities. Second, the approaches must be matched to the specific problems of these women and infants. Communities, therefore, must be able to assess their problems, direct scarce resources, and provide ongoing monitoring to track improvements and better understand causes.

Finally, while we are convinced that efforts such as those I've described could save many lives, there is still much we need to learn about the biological and behavioral causes of infant mortality. Basic and applied research on questions relating to preterm births and other conditions related to poor pregnancy outcome needs to continue.

The United States Public Health Service has just issued for public comment draft versions of the National Health Objectives for the Year 2000. Among these Objectives are the reduction of infant mortality to 7 deaths per 1,000 live births. The remaining maternal and infant health objectives for the year 2000 also propose quantitative measures covering such areas as health status, risk reduction, public awareness, professional education and awareness, and services and protection.

These objectives can serve as a yard stick to guide and assess our progress. They give us a challenge to share, and provide a focus for the development of a national strategy to, in the words of President Bush, "Give our children a better start in the world (and) see that quality health services so critical for improving maternal and infant health will be available to all pregnant women and young children in our Nation." We in the Department of

Health and Human Services are working hard now at doing what we can to remove barriers to receiving care, enhance service delivery, and improve knowledge among the scientific community and the general public and welcome the opportunity to work with States, local communities and the private sector.

Thank you. I will be pleased to answer any questions you may have.

Chairman MILLER. Thank you. I thank you very much for your testimony. Let me just, if I might, ask you a couple of questions. We had goals for 1990 in infant mortality which were to be 9 deaths per 1,000. Is that correct?

Dr. MASON. That's correct.

Chairman MILLER. And we missed that mark, apparently, or appear to be missing it. Right now it's around 9.9.

Dr. MASON. That's right. We undoubtedly in the few remaining months before we hit 1990 won't be able to achieve that goal. We probably will achieve it as a sub-goal for our white population, but we're not going to get near it with regard to our black and minority population. And so the overall goal will not be reached.

Chairman MILLER. For the overall population?

Dr. MASON. That's right.

Chairman MILLER. Because of that? And the goal for the year 2000 would be what?

Dr. MASON. We're in the process of drafting goals for the year 2000, and that won't be completed until we get input from more than 9,000 institutions and individuals that have been mailed copies of the draft.

But the provisional draft goal would be a target of 7 deaths per 1,000 births in the United States by the year 2000.

Chairman MILLER. Well, given the current status, if you will, and the number of things that you recite in your testimony, what would be the strategy for achieving that goal?

Dr. MASON. Well, I think the strategy, as I said, the information we need to achieve that goal is here, although I don't want for a moment to say that we don't need to continue to do research on maternal and child health, because we have within our grasp the ability to reduce about by one-fourth with current knowledge.

And we need to do that rapidly, but we need to also produce and pursue a research agenda to get at the other three-fourths. But for that one-fourth I think the basic fundamental item is that we get people early into good prenatal care, we remove the barriers, get them in there, every pregnant woman.

And to get them in, it means more than just passively waiting for women to appear at the doors. First of all, the clinic has to be attractive, and it has to include such concepts as one-stop shopping.

But there has to be an outreach for those women who are unlikely to come in by themselves, who don't understand the need for early prenatal care. So using the case management program, outreach, volunteers, people in the community who can help in that process, we need to be delivering those services that would correct the underlying problems that result in low birth weight and infant death and——

Chairman MILLER. Am I correct when I believe that there are pregnant women who are currently on waiting lists for programs like the WIC Program?

Dr. MASON. That's correct. There are.

Chairman MILLER. So we have an identifiable population that is sitting out there on a waiting list and we're not getting to them.

Dr. MASON. And, certainly, those barriers need to be removed.

Chairman MILLER. Well, coming from this committee I must tell you, I was very excited when, in fact, we had a debate between

Governor Dukakis and President Bush on these issues. It actually became an issue in the campaign, which was startling to me that this would happen because it never has before, but here it was—discussions about WIC and the President's notions that we had to have sufficient funding for WIC and we were going to have a phase-in of Medicaid up to 185 percent of poverty for children and families.

But what concerns me, and what just jumps out at me in your testimony, is the admission that you estimate that we could save 10,000 of the 40,000 babies who die each year. Between now and the year 2000, that would be 100,000 babies.

And it would seem to me that there would be some urgency in eradicating those waiting lists with respect to the pregnant women in WIC and their infants.

Now, I understand, as the children get older in that program, we prioritize. And that's apparently necessary, given the budget constraints, but with respect to that target population of women who are waiting and we see the success, I don't understand the hesitancy.

Now, in the area I represent, if you come into a WIC clinic, it's one-stop shopping. You have now entered the public health system at that point. You may have come for nutrition reasons but you're now in that system.

And I visited a number of WIC clinics in other parts of the country where that is true. I just wondered: Where are you in reducing those waiting lists?

Dr. **Mason**. We are very concerned about waiting lists. Women and infants who need these services as rapidly as possible ought to be brought into the system. I have to say and I——

Chairman **Miller**. Having said that, how are we going to do that?

Dr. **Mason**. Well, I have a problem with the WIC Program because it's not part of Health and Human Services, and I don't want to make it appear that I don't really care about it. I do.

It's part of the Department of Agriculture, and that's where we need to work with them. And we need to work cooperatively with the Administration and Congress to see that some of those barriers are reduced because I am very sympathetic to the things that you are talking about.

And we may or may not have one-stop shopping out there. I want to make that clear that in some communities, they have pulled that all together so that when you go to get WIC benefits, you find community health clinics and Medicaid eligibility all offering services at one site.

Unfortunately, this does not occur comprehensively across the nation. That is one of the things that we are trying to work on within the Department in reaching out to Agriculture and other parts of the federal establishment to see that direction of one-stop shopping and common eligibility is——

Chairman **Miller**. I assume, therefore, Dr. Mason, that we would look forward to your support for—it was reported out of Committee—the revisions requiring development of a model single application form for pregnant women and children for WIC and Medicaid and Head Start and the maternal and child health programs that are being put forth in the Reconciliation Bill.

I would hope you would take a very serious look at that because I think that's an effort that is moving us toward the direction that you and Mr. Bliley and a lot of us are concerned about.

Dr. **Mason**. I chair a White House task force on infant mortality, which has representation on it from all of the departments of the Executive Branch that have any role with regard to infant mortality and children. And we have a subcommittee that is looking at that very matter. We're concerned about that issue.

Chairman **Miller**. What is the status of that task force?

Dr. **Mason**. We're working and going to be making recommendations to the President on what we might do on——

Chairman **Miller**. Do you have a time line for that?

Dr. **Mason**. Within the next few months, that work will be completed.

Chairman **Miller**. And the nature of those recommendations will be what?

Dr. **Mason**. Well, I think conceptually we want one-stop shopping to occur. And what we're trying to do is get together as departments and agencies and find out what we can do with regard to the application for services.

Can we simplify? Can we consolidate? Can we bring these things together and not only application-wide, but can there be physical coalescence of these kinds of things? And that's what we're working on.

Chairman **Miller**. That's several months from now. That will be 1990. What are you going to do about these 10,000 babies that apparently are going to die needlessly?

Because, as you point out and I think you correctly point out, we have the ability to stop this should we desire to do it. It is one of implementation.

Now, you have identified these babies. Now, what is the task force, what is the Administration going to be recommending to us to stop those 10,000 babies from dying?

Dr. **Mason**. I have already indicated what the Administration has done with regard to the 1990 budget. We are going to push ahead to expand the coverage of Medicaid for a larger proportion of those women and we hope with time to bring each woman into the realm so that she's eligible early on.

And we want to work cooperatively with Congress in that process.

Chairman **Miller**. I don't have to lecture you, Doctor. You know. You used the key phrase, and that's "time." These pregnancies don't understand our fiscal years and our task force deadlines.

But it would seem to me that a great urgency should be attached to the fact now that we have identified the population. You're almost in the ethical position of withholding services from that population when you have arrived at the conclusion that you know how to take care of them, that you could impact on an outcome.

And I'm not suggesting that that burden falls only on the Administration. It falls here on the Congress also.

Dr. **Mason**. And on the private sector and——

Chairman **Miller**. But having identified that population and recognizing that pregnancies are underway and that pregnancies will be underway tomorrow morning and the next morning and the next morning that have no references to our fiscal years, I am just trying to figure out how we translate this sense of urgency to this problem.

Dr. **Mason**. We have a sense of urgency, and I think we need to work with you. We need to work with states, with local government, with the private sector because I am sure that we don't have a simple single solution to this problem.

But, by golly, I think we are determined to work with you, with others to see if we can't get those 10,000 babies saved.

Chairman **Miller**. Congressman Bliley?

Mr. **Bliley**. Thank you.

Dr. Mason, what are the most important reasons why we will not meet the 1990 health objective of an infant mortality rate no greater than 9.0 per 1,000?

Dr. **Mason**. There are a number of reasons why that won't occur, but I think the most important one is, again, the lag in the black infant mortality rate. We need to provide a way to reduce that rate. And if we could reduce that rate, then we would easily have come within the target.

So if I were to start anywhere, it would be by making sure that we were targeting services to those communities where infant mortality rates are particularly high. That would largely be in our underserved inner cities, some of our underserved rural areas.

And there we need not only access, but outreach, case management, all of those services in a coordinated way to provide what we know will do something about the problem.

Mr. **Bliley**. The report of the National Commission to Prevent Infant Mortality states that the "lifetime costs of caring for a low birth weight infant can reach $400,000. The costs of prenatal care that might prevent this low birth weight condition in the first place can be as little as $400."

Part of the problem, according to the survey I conducted in 40 counties across this country, is that only 38 percent of the publicly supported facilities offer prenatal care. Although half of the public health departments offer prenatal care, less than a quarter of the private nonprofits offer prenatal care.

Shouldn't we perhaps place more of an emphasis on funding only those facilities which offer prenatal care?

Dr. **Mason**. Let me give you a short answer and then turn this over to Mr. McGee. But we believe that services ought to provide comprehensive—that whenever possible, a woman ought to be able to go one place and get primary health care, prenatal services, services for her baby.

The problem of using buses, of transportation, the barriers that cause problems when you have to go to multiple sites for care is really a serious problem.

And so we feel that we ought to move as rapidly as possible to aid those clinical services that do not provide prenatal care, to assist them in bringing up those services, wherever possible, so that a woman who enters there or brings her child there can have comprehensive services.

Mr. **McGee**. I guess I would add to that that we have currently funded any number of projects, probably around 30 to 40 projects, around the country that focus on getting women into care in a single location and improving the care package that they get in that location. Those are primarily done through state and local health department grants.

And I guess going back to what Mr. Miller, the Chairman, said earlier with respect to the WIC Program, we are working daily with the people in the WIC Program with respect to coordinating the services of the WIC Program, which, as you know, are focused on nutrition.

We have a nutrition component in our program in the Public Health Service, where the people there are working under the auspices of former agreements with the WIC people to assure in the state health departments the Title V Program, which is a major part of the Public Health Service, which is focused on maternal and child health, with respect to the block grant and some discretionary grant activity.

We are working to make sure that those programs are supportive and interreact with the WIC Program. And I think it's working actually quite well. There is a problem of resources, as always.

Mr. **Bliley**. Well, the problem that I see is that only 38 percent of the states and local health people are participating in prenatal care. How do you suggest that we get that improved? Because unless we do, we're going to have a hard time meeting any targets.

Dr. **Mason**. I think that all of our states receive maternal and child health block grant services and also have Medicaid funds that enable them to provide prenatal care services. Now, whether they integrate that into a comprehensive service, that may not occur in this or that community, but all states at least have provision using federal funds for prenatal services.

Mr. **McGee**. That's exactly correct. All of the states do get the block grant. In most all of the states, I would say probably close to 50, there is an official unit in the state health agency that has purview for MCH programs. The major support for that comes out of the Title V block grant.

Mr. **Bliley**. Well, my time is limited. I would like to ask one more question. You pointed out how important it is—and I certainly agree, and it is the thrust of the legislation that I have introduced—that one-stop shopping for these people, where they can get all of this, is so very important.

Shouldn't we encourage this by giving extra grants to those communities that would do this?

Dr. **Mason**. I strongly believe we ought to encourage one-stop shopping as a concept and through the use of the maternal and child health block grant and other funding, whether it is block or categorical.

I think that there ought to be certain strings attached to that money so that states, local communities move as rapidly as possible into that mode.

Mr. **Bliley**. Thank you.

Thank you, Mr. Chairman.

Chairman **Miller**. Congressman Rowland.

Mr. **Rowland**. Thank you, Mr. Chairman.

And thank you for your testimony.

The problem is not a medical problem. The problem is a social problem. In my opinion, if we look back at what has taken place over the last 20-odd years, we will, I believe, find that our focus has been on technology.

There is no country in the world in my opinion that has better technology in neonatal intensive care than does the United States.

In the late 1950s Japan had the 18th or 20th high low infant mortality or high infant mortality rate. We were number five. Now our positions are almost reversed. We are number 20 or 21 and Japan is number 1.

We found in some hearings that we had at the United Nations in New York that there were representatives from around the world who came and testified about what they were doing.

And in Japan what they did was focus on getting pregnant women to go to the doctor. It's almost as though they are ostracized from society there if they don't get prenatal care and do not go in to get the things that they need to get. So it seems to me that that is where the problem principally is.

And I wonder if you might agree with me, Dr. Mason, that with the advent of Medicaid in 1965, that prior to that we had public health clinics where we provided prenatal care for women, and it was largely a focus of the local community.

It got these women to come in and get their prenatal care, but it was assumed after 1965 that since Medicaid would pay for their care, then these clinics no longer existed.

And the fact is that many women who were eligible for Medicaid or had Medicaid didn't come in for that care at all. Consequently, our low birth weight incidence went up. That is, in large part, responsible for the position that we find ourselves in now.

I was also interested in what you mentioned about the malpractice litigation problem. There is not much attention being focused on that, but in my opinion this is one of the principal problems that we're having now.

And I can see that in the not-too-distant future, there will not be many people doing obstetrics. This, of course, is going to cause an increase in our infant mortality rate. Would you agree that that's probably true?

Dr. Mason. I would agree with you both with regard to Japan and on the malpractice issue. I think the issue of malpractice, if we're not going to deal with it as a nation generically for all specialties or family practice, as least we ought to concentrate on the obstetrical malpractice issue because this is making the job just that much harder to provide quality services in underserved areas.

And if we don't intend to take on the whole program, please let's at least decide how we can ease the situation around obstetrical malpractice. Because with everything else going on, we can't afford to add that to the list of reasons why we're having high infant mortality.

That, indeed, is a significant problem. And I think we have to look at enacting tort reforms or imposing caps, implementing alternative dispute resolutions.

We really need to look at that. We intend to do that within the Department, and we hope the Congress will look at that with us.

Mr. **Rowland**. We have some language in some of the legislation that we have in our Health and Environment Subcommittee to look at that very thing. I don't believe that there are any other of the countries that have lower infant mortality rates than we do that have a contingency fee system.

Are you aware of any of those countries that may have a contingency fee system?

Dr. **Mason**. We're not aware. We could get more information if you'd like, but I'm not personally aware of it.

Mr. **Rowland**. It's really a social problem in my opinion, and it's going to have to be an effort on the part of federal, state, local government to deal with this as well as various groups in local communities, church groups, civic organizations, business community. Everyone is going to have to work together in order to get us in a better position insofar as our infant mortality rate is concerned, I believe.

Dr. **Mason**. I agree totally. And although I well recognize the need for more resources to provide specific services, resources alone won't do it. It's going to have to be a concern at every level in this nation.

And, finally, it has to be the concern of the pregnant woman itself, and I'm not blaming the victim. But if that concern isn't expressed at all levels, then just throwing money at the problem won't solve it.

Mr. **Rowland**. Thank you.

Thank you, Mr. Chairman.

Chairman Miller. Congressman Walsh.

Mr. **Walsh**. I have no questions at this time, Mr. Chairman.

Chairman **Miller**. Congressman Machtley.

Mr. **Machtley**. I just wanted to follow up on that resources alone will not take care of the problem. As I understand the testimony, 10,000 of the 40,000 deaths could be prevented in some way.

You indicated in your testimony that low birth weight is the number one factor in deaths of infants and, furthermore, that the babies which are born with low birth weight are going to cost us $2 million in remedial health care, but that we could prevent that with an expenditure of $500 million annually.

Dr. **Mason**. That's correct.

Mr. **Machtley**. Why don't we just spend $500 million annually? I mean, it's a business. Let's try and take the emotion out of it and look at it from a business standpoint. If we can save $1.5 billion, why don't we just say, "Let's get together, Congress, and let's spend $500 million"? We'll save 10,000 babies.

Dr. **Mason**. This is the message that public health has been giving for the last 20 years, not only with regard to infant mortality, cancer of the lung related to tobacco, cancer of the cervix related to PAP smears.

We can show you not just in infant mortality, but in a whole list of areas where this nation is spending dearly not only in terms of human life, but in terms of cost due to chronic disease and disability.

And we have traditionally chosen year after year, decade after decade to fund treatment rather than the preventive side of this. We run up against this day after day.

And we appreciate your recognition that that's what we really need to do.

Mr. Machtley. So you would agree that we should then get together and spend $500 million and save?

Dr. Mason. We need to save those $2 billion because it isn't just that after we spent the $2 billion, everything is okay.

But after we've spent the $2 billion, many of these babies whose lives have been saved have chronic pulmonary disease. They have central nervous system problems. Many of them will never be independent individuals as a result of low birth weight.

We spent $2 billion, and we have kids who aren't going to function the way they were designed to function. And wouldn't it be better to not have that $2 billion cost and have kids who are going to grow up and be bright and productive and responsible and independent?

Mr. Machtley. Just one follow-on. If 25 percent of low birth weight is a result of smoking—I believe that was the statistic you gave—what progress are we having in young mothers stopping their smoking?

I understand in my circles of friends smoking is no longer socially acceptable. How are we doing with young mothers?

Dr. Mason. Among women, we're not making the same progress on smoking that we are, interestingly, with men. Among poor people and minorities, we're not making the same progress. Tobacco companies today are targeting women. They're targeting the poor. They're targeting minorities.

Now, if we can get these women early into prenatal care, most of them understand that when they smoke, when they use drugs, when they use alcohol, they are smoking for two people, themselves and their baby.

And it's often easier to get them off these addicting substances during pregnancy than during any other time of their lives. And that's why it's important to get them into prenatal care.

That's where you handle specifically the smoking, the drugs, the alcohol, the malnutrition, the iron deficiency. You can handle underlying disease problems, like hypertension, diabetes, infection, all of these things that are going to result ultimately in low birth weight babies.

Mr. Machtley. Thank you, Mr. Chairman.

Chairman Miller. In this committee, I don't know if it was the National Institute of Medicine or Health that suggested we could do that all for about $600 or $700 a pregnancy, that kind of counseling and that kind of preventative work, as opposed to $1,500 a day to take care of these babies after they're born.

Congressman Levin.

Mr. Levin. Thank you.

So, Dr. Mason, let me just ask a single question following up your testimony that we could save 10,000 infants just by applying what we already know about things like case management, outreach, and home visiting.

So tell me as simply as you can: Why don't we do it?

Dr. Mason. I could ask you the same question. I think one of the reasons is——

Mr. **Levin**. I will be willing to answer that, but you have the benefit of testifying, and we're not supposed to.

Dr. **Mason**. I will just say what I said earlier. As a nation, we are so enamored with high tech and with treatment. We're enamored with cure, but there are few things we really cure.

We're enamored with treatment and high tech, and we'd rather put an infant in a newborn intensive care unit than go to the trouble and difficulty to get out in front on the other end.

Mr. **Levin**. Well, wait a minute. What's difficult? You talked about intricate and difficult, but you say we could save 10,000 lives just. The word "just" is in there. That means simply by applying what we already know: case management, outreach, and home visiting. So why don't we do that?

Dr. **Mason**. I want to do that.

Mr. **Levin**. Well, are you going to do it by next year?

Dr. **Mason**. Are we going to do it by next year, the Congress, the Administration, the states, the locals?

Chairman **Miller**. Will the gentleman yield?

Dr. **Mason**. I think we've got to work to bring that to pass as rapidly as possible.

Chairman **Miller**. Will the gentleman yield? And let me just say that this has been proposed time and again by the Congress.

You're representing a new Administration. We're about to go into a new budget year. This budget year is so screwed up nobody can tell what we're going to do.

But let's assume in January we start with a clean slate. I think the question is: If the President would support this effort on a budgetary basis, that we're going to get back, apparently, $2 for every $1 we spend. And the March of Dimes and others tell us that we're going to get more than that, but let's assume that.

On the basis of humanity, if the President joins in this effort, this could be done within the next fiscal year. I think that's the issue. And I would hope that's what the task force would address, that we need two willing partners here.

We have suggested time and again to the Congress that this be done, and we were knocked down by the last Administration.

This is a new day. You have a sense of urgency. You've recognized that there are 10,000 lives at stake here, each and every year we don't do it.

So, I think what you're hearing here is if that could be brought back to the councils and the task force, they're right. We may have to spend some money.

But all the evidence is we would get that money back in a very short period of time, probably the fastest rate of return that this government has ever seen.

Excuse me.

Mr. **Levin**. No, no. I think you say it so clearly.

So I just want you to respond. Why don't we do it?

Dr. **Mason**. I want to simply say: Let's do it.

Mr. **Levin**. Well, but not let us. Are you saying we will do it?

Dr. **Mason**. I would like to see us do it.

Mr. **Levin**. No. That isn't good enough. Look, I very much respect you, Dr. Mason, believe me. And I understand the circumstances under which you're working.

But we're now talking not about the 30,000, where there are more intricacies. I mean, I'm not saying this is an utterly simple problem, but your testimony says we could save 10,000 of the 40,000 babies just by applying what we already know.

You leave open, when you say that, the obvious question, which unfortunately isn't answered usually. If it's so clear, why aren't you doing it? Why isn't it in the budget?

Dr. **Mason**. Well, I think it's very clear from what I said earlier that President Bush put into the last budget of the former Administration a proposal to increase the poverty level from 100 percent of poverty to 130 percent to bring almost 4,000 additional women in. I think that shows a commitment on the part of the Bush Administration to do something about this problem.

Mr. **Levin**. Okay. To do something. But is that change going to save 10,000 lives?

Dr. **Mason**. It won't save 10,000 because it won't bring all pregnant women into the field.

Mr. **Levin**. Okay. Then I ask you: If we can do this simply, why aren't we doing it immediately? And give me a simple answer because it's a clear statement and a simple question. Why aren't we when it comes to human life doing the simple thing?

Dr. **Mason**. Well, we've had the information that we present before you today for at least the last 20 years.

Mr. **Levin**. Right. But you——

Dr. **Mason**. This isn't new information that we're bringing to your attention for the first time. We in public health have told you this year after year after year.

Mr. **Levin**. Okay. But wait a minute. George Miller has already answered that in a sense because there's been a proposal from the Congress.

But you're now running the show. You're into your second budget. We haven't written this budget yet. Why aren't we doing it for 1990?

Dr. **Mason**. President Bush increased it from——

Mr. **Levin**. I know, but you say that won't save 10,000 lives. Why aren't we doing it?

Dr. **Mason**. I think you and the Administration have to look at the total budget. There are other priorities that I don't deal with that relate to—we're not just talking about infant mortality. We're talking about AIDS. We're talking about drug abuse. And that's where someone outside my realm of responsibility has to look at where money is going to go.

Mr. **Levin**. All right, sir. But now you're giving me, you're giving us, I think, a forthright answer. Essentially, in simple terms, what you're saying is: Here's something that we know how to do. I'm talking about the 10,000. And the reason that we're not doing it is because of other priorities.

Dr. **Mason**. That's right.

Mr. **Levin**. Okay. Now, I just——

Dr. **Mason**. We have priorities.

Mr. **Levin**. You need to—and I'm not suggesting you're the Director of the Office of Management and Budget. I know you're not. So you can't tell us how you balanced all these priorities.

But I think that kind of an answer is what America needs to hear. What you're saying, in simple terms, is: It is deemed that we don't have the money in this country to save 10,000 lives. Isn't that really what you're saying?

Dr. **Mason**. Yes. And we could save 6,000 deaths from women for cervical carcinoma. In other words, we've got to decide whether we save 6,000 women, 10,000 children, this, that, and the other. And it's balancing where we're going to put our money.

Mr. **Levin**. So, essentially, you're saying that those 10,000 lives are lost because we are going like this. [Indicating.] Right?

Dr. **Mason**. We are all trying to assess priorities at the federal, state, local, whatever level as to what is most important to society.

Mr. **Levin**. All right. I just think that everybody in this room and in this Congress and everybody who's running these programs, including the President of the United States, has to understand that when the US says it doesn't have the money, we are losing 10,000 lives that could easily be saved.

Chairman **Miller**. Mr. Hastert.

Mr. **Hastert**. Thank you, Mr. Chairman.

I would like to progress on the gentleman's comments across the podium from me here.

But, you know, it seems that there are a lot of priorities. It seems like there are a lot of problems. And those 10,000 people at risk, maybe if we had the new dollars to stick in that program, we could start to save some lives.

But it seems like there are other problems. What percentage of these people are the inner-city people who have problems with crack and cocaine, for instance? Is that a factor here?

Dr. **Mason**. Absolutely. And so it isn't just putting money directly into prenatal care. The money that is going into smoking cessation, drug abuse all is having a factor upon infant mortality.

Whether we succeed or fail in a lot of different areas is very fundamental to whether we succeed on the infant mortality side of things because it isn't a single-faceted problem.

It's a multi-faceted problem, and we've got to succeed in a number of different areas.

Mr. **Hastert**. Well, it seems to me that you weren't here, of course, but in proceeding before this very same Committee, we had people come up and telling us that people who were addicted to crack and cocaine were dumping their children in garbage buckets and you couldn't bring them into any type of community service, that they were, essentially, running wild and back on the street nine hours after giving birth.

So it would be difficult bringing some of those people in. I'm just saying in a perfect world, maybe we could save 10,000 people right away. But there are other problems that you have to solve first, before you can start to deal with a perfect world. Is that correct?

Dr. **Mason**. That's correct, but I don't believe that our statistics really have caught up with us yet. So that we're not really seeing in infant mortality statistics the impact of drugs.

In other words, I think many communities, such as Washington, D.C., have already shown an increase of infant mortality.

So we're using data that is basically '87'88 data, where there was drug abuse and crack and the problems that you are talking about.

But I think we have yet to see the impact of that in terms of national statistics.

Mr. **Hastert**. So you're saying the inner-city statistics, then, could be worse?

Dr. **Mason**. I think as we see the full impact of some of our inner cities being reflected in infant mortality, you're absolutely right, that prenatal care alone will not solve this problem if we don't get on top of the—a lot of these babies that are dying of AIDS. They're dying of crack and the direct result of drug abuse.

To put all the money in prenatal care services would be very useful, but if we don't control other sectors of the problem, we're going to end up with difficulty as well. All of this has to be brought down together.

Mr. **Hastert**. And then also it would seem to me, and according to the other testimony that we have here, that it's awful difficult to bring those people under the tent, so to speak, to get them in line to sign up for these services or to get them into the places that can, the clinics that can help them.

Dr. **Mason**. That's why you have to have the outreach services. We found in working with the American Indians that even though it's 30 miles by dirt road to the clinic, obviously, they don't come early, but if you get a case worker or a village volunteer who becomes concerned about any pregnant woman in the village, then things begin to happen.

It isn't enough to just have access. There has to be a way to get these women to come in. And if you don't have the outreach, having doctors standing there in the clinic isn't going to solve the problem, only part of it.

Mr. **Hastert**. I'm not trying to lead you. I'm also not trying to badger you, but I want to say here that I think it's important that we need to look here and see what the stage is and see what the problems really are. And maybe then we have to order our priorities before we can really get at the problem that you want to address.

And with that said, Mr. Chairman, I relinquish my time. Thank you.

Chairman **Miller**. Mr. Durbin.

Mr. **Durbin**. Thank you, Mr. Chairman.

Dr. Mason, I'm sorry I missed your spoken testimony, but I have read your statement.

I'd like to say at the outset that I'm particularly enamored with your quote here where you said "I think we ought to be more concerned about Japan's lead over us and its ability to produce healthy babies than its ability to produce cars or electronics." I plan on using that quote. I plan on crediting you at least the first time I do. I wanted to let you know in advance.

My colleague from Rhode Island raised an interesting point earlier. I had never heard anyone quantify the cause of low birth weight attributed to smoking at a figure of 25 percent.

Is that in your testimony or are you familiar with that?

Dr. **Mason**. I'm not sure it's in my testimony, but it's a well-recognized figure that about 25 percent of low birth weight infants can be directly related to smoking and about 10 percent of infant deaths.

Mr. **Durbin**. Let me ask you, Doctor, is it fair to conclude as well that we have a higher incidence of low birth weight among lower income individuals?

Dr. **Mason**. Absolutely.

Mr. **Durbin**. All right. Then I would like to ask you in your capacity, a significant capacity with the Administration, if it wouldn't make sense for us, then, to promote the increase in excise taxes for tobacco products so that they become more expensive for lower economic groups to purchase, thereby discouraging the habit and leading to a lot of positive developments, including perhaps a reduction in infant mortality?

Dr. **Mason**. I would rather not comment on this because it might be looked upon as a tax increase.

Mr. **Durbin**. As a what?

Dr. **Mason**. A tax increase.

Mr. **Durbin**. Well, forget about that for a minute. Let's talk about health for a second, Doctor. I mean, you really have to look this thing right in the eye. And if we're going to be serious about dealing with it, let me just ask you in the most general terms.

And I'll start off with the caveat that we're not going to say you endorsed a tax increase. From a health perspective, if we raised the cost of tobacco products so that lower economic groups would be discouraged from buying them, wouldn't that have a positive impact on the health of America?

Dr. **Mason**. It's been shown in Great Britain with regard to wine and spirits that by raising the cost of wine and spirits, the alcoholism rates go down significantly.

And it's always inferred, or it is inferred in the United States and everywhere, that if you raise the cost of tobacco, you discourage, particularly young people, from beginning the habit.

And it has an effect on the whole economy. So the cost is a major factor in how many people use tobacco and how much tobacco they use.

Mr. **Durbin**. And the obvious conclusion is that if fewer young people use tobacco, what impact will that have on the health of America?

Dr. **Mason**. Oh, it would have a tremendous effect because we're still losing 1,000 people a day, 1,000 funerals a day as the direct result of tobacco use.

And the tobacco companies know that if they don't hook young people by the time they're age 21, they'll never get them.

So anything we can do to discourage adolescents and kids from smoking, it's going to pay dividends that are extraordinary.

Mr. **Durbin**. I'm not going to consider that an endorsement of a tax increase, but I appreciate your candor.

Let me move to another related issue. Do you feel that the issue of teen pregnancy has a bearing on the infant mortality rate in our country?

Dr. **Mason**. Absolutely. There's no question that teenage births are more likely to be low birth weight and the teenage girl also has greater difficulty in terms of raising the infant if she keeps it.

So there are a number of risks that go along with adolescent pregnancy, often the environment. There isn't the nurturing environment for her or for her baby.

So whether we're talking about tobacco, alcohol, drugs, or just services—and often there is a denial of pregnancy, and so they don't get prenatal services until they're later in their pregnancy.

There are a whole series of events that occur. But just basically biologically, kids shouldn't be having kids. They ought to become physically mature.

Mr. **Durbin**. What public policy initiative will the Bush Administration be proposing to deal with teen pregnancy?

Dr. **Mason**. As you know, we have Title X, Title X that are working on aspects of that. We feel strongly that there are ways that one can approach that and that we ought to be doing everything we can to discourage teenage pregnancy, teenage sexual activity.

Mr. **Durbin**. Dr. Mason, those programs existed before the Bush Administration came into office. Is there any new initiative or anything that you're going to suggest that you would consider as the Bush approach to dealing with this problem?

Dr. **Mason**. Not that I'm aware of at this point in time.

Mr. **Durbin**. Can I ask you specifically? On our reconciliation bill, we're faced with two aspects of it which relate directly to this issue and problem. One is an increase of Medicaid eligibility to 185 percent of poverty. Do you support that?

Dr. **Mason**. I'm not sure where the Administration is on that. I'm not sure that they support that.

Mr. **Durbin**. Wouldn't you say that bringing more women under the protection of Medicaid, particularly those in the income group I've just described, would have a positive impact on the health of our country and, particularly, on the infant mortality problem?

Dr. **Mason**. Yes, it would.

Mr. **Durbin**. And you're not certain where the Administration is on that issue?

Dr. **Mason**. That's right.

Mr. **Durbin**. What about the proposal for an additional $100 million in maternal and child health care grants? Are you supporting that aspect of reconciliation?

Dr. **Mason**. I'm not sure where the Administration is on that. I don't think they have supported that.

Mr. **Durbin**. Wouldn't you conclude that that additional money might help to improve the health of this country in reducing the infant mortality rate?

Dr. **Mason**. If it were focused and targeted, it probably would be beneficial.

Mr. **Durbin**. As I understand it, the program is focused and targeted.

Chairman **Miller**. Congressman Packard.

Mr. **Packard**. Thank you, Mr. Chairman.

Much of the discussion thus far has been on providing additional funds. Are there not other procedures that could be implemented that do not simply take on a welfare aspect of providing funds for those who do not have funds or are choosing to use funds elsewhere?

Is there not some educational procedure that could be implemented? Would you speak to that portion rather than simply the providing of additional funds for prenatal care?

Dr. **Mason**. There's no question that the education and information side of this is absolutely imperative if we're going to succeed. The concepts of accountability and responsibility in terms of one's personal behavior are significant factors in infant mortality.

But wherever you start, whether it's education and information in our schools, whether it is information that comes in the home, family values, talking to young people about sexuality, abstaining, if they're going to be sexually active, to make sure that pregnancy doesn't occur, there are a whole series of steps that need to be taken.

And, as I said earlier, just throwing money at this problem will not produce a solution. It has to be an integrated, comprehensive approach.

And, ultimately, you have to get down to the individual woman. She ought to want to have a baby if she's going to have a baby. She should use services that are available. And she should recognize that, whether she's smoking or using drugs or whatever, this is important that she prepare for that baby.

Also there are organizational changes that we have talked about, like one-stop shopping, that shouldn't add to the budget deficit, the use of volunteers in our communities to reach out to pregnant women and make sure they get in.

So there are a lot of things we can do without raising costs.

Mr. **Packard**. Certainly a healthy educational program would help parents to realize that they too have to prioritize, just as the federal government has to prioritize.

We simply cannot come up with the money to do all that we would like. We have to prioritize. Families have to prioritize.

So they need to be educated to make good priority judgments. I think that would be an important part of any program we would want to involve ourselves in.

Thank you.

Chairman **Miller**. Congressman Sikorski.

Mr. **Sikorski**. Thank you, Mr. Chairman.

I commend you, Dr. Mason, for your testimony. I had a chance to read over it. I, too, missed your verbal testimony.

But the debate this morning has kind of focused on this old throw-money-at-problems argument, which is an endless argument. But I'd like to put some parameters on it.

It's more than throwing money at a problem. It's a question of who's making policy for America and for our taxpayers who pay for it.

It's not our money and it's not the Administration's money. It's the taxpayers' money. Who is making public health policy in this country?

And if you look at the last decade, it's not the Public Health Service, and it's not Health and Human Services, not the National Institutes of Health. It's the Office of Management and Budget. In that fight of alphabet soup, it's not NIH or HHS or PHS. It's OMB.

And we should have the Wizard of Oz curtains and bells and buzzers and smoke—all here at the time we say it. They're the ones who are making policy. And that's the problem.

When you're penny-pinching and making public health policy, it shows up across the board. You've already noted that we cost more by penny-pinching than we save.

We would save if we put the money into these basic programs and do the cheaper programs at the beginning of the problem than we pay—what is it, $10,000 a day?

How much is it a day to keep a preemie, a severely disabled preemie, in an intensive care unit for two months? $100,000? $50,000?

Dr. **Mason**. $1,500 a day approximately.

Mr. **Sikorski**. It's $1,500 a day. That's $45,000 a month. Two months, that's $90,000. For that, you could outreach. And to do education programs, that takes money, too.

So it's not a question solely of saving money. Unfortunately, when they count the pennies at OMB, they count them on the way out, and they never count them when they show up later on in reduced outlays because we're saving taxpayers money and we're saving deformities and limbs and lungs and human lives over there.

And, secondly, I'd argue that people like you, talented people, people who have technical backgrounds, should be making the public policy, not a bunch of lawyers and economists over at the Office of Management and Budget.

George Bernard Shaw said if all the economists in the world were laid end to end, they'd never reach a conclusion. And he said if all the lawyers—and I'm one of them—were laid end to end, it'd be a good thing.

When we have the budget in the Office of Management and Budget driving public policy in health—I fight this on a daily basis on the Health and Environment Subcommittee—we don't have the people who know making the decisions for the taxpayers. And I think the taxpayers get cheated.

Secondly, we can talk about the Red Cross. We can talk about 1,000 points of light. But the fact is, when we're talking about 10,000 human lives in a pro-life Administration, we should at least guarantee a basic infrastructure so that those 1,000 points of light can beam brightly.

And we're not providing that basic infrastructure as a federal policy. And I would argue that if we do anything as a federal government, we should be saving those lives at the early end.

So I guess I have no questions. Maybe you'd like to make a comment. I just think that this debate of throwing money, throwing money, throwing money isn't the way the debate is properly framed.

We're saving money. We're trying to get minimum commitment so that the others, the nonprofits and the profits and others, can build upon that. And we want the people who know making basic public policy in this country.

And I want to commend you for sticking your neck out here and there this morning.

Dr. **Mason**. Just one comment if I might. We're concerned about our state and local health departments. The Institute of Medicine about a year ago put out a monograph called "The Future of Public Health." And they praised the local and state health departments for what they had accomplished with the resources that they had.

But they said that because of under-funding at the state and local level, public health in the United States is in disarray.

And, you see, not only do I have to decide within a certain budget where I'm going to put my priorities, but the same thing is going on at the state and local level.

And you've got to keep a number of balls in the air simultaneously. The calls for services at the local level are not just for infant mortality or prenatal care. They're called upon to be involved in a lot of areas, and they have to establish their own priorities.

And I should think that every one of them would say, "Let's put all our money in this one area," but there are lives to be saved in a number of different areas and needs to be met.

And that's what I think we are really working on. Within what we have, we have to put the money where it will do the most good.

Mr. SIKORSKI. I think you reminded me of a point that I lost when I started quoting George Bernard Shaw. And the point is: We're not talking about meaningless gestures to the poor or some quick-rip schemes for health professionals or others to do some busy work out in the community. We're talking about basic health programs that provide healthy bodies.

And if you're an economic determinalist and you're only looking at what it means for the economy, you can't run a national economy without healthy human beings. You can't fight an international trade war without healthy human beings.

These two issues are you can't have a good health program without good tax-paying, functioning, productive economy providing the support.

Likewise, you can't have a good economy and a nationally, internationally competitive economy without healthy human beings. They fit into each other. And we're missing the boat right at the beginning here on these several thousand human lives.

Thank you, Mr. Chairman.

Chairman MILLER. Congressman Wolf?

Mr. WOLF. I have no questions.

Chairman MILLER. Mr. Evans?

Mr. EVANS. I have no questions.

Chairman MILLER. Dr. Mason, thank you very much for your testimony. And let me just say that I think that you can hear it here. And I don't think this is partisan. I think what we're looking at is the opportunity of the new Administration.

You know, I can remember going to a dinner to kick off the campaign for healthy babies right from the start. I believe it was the March of Dimes campaign that started a number of years ago. And the attraction at that dinner was that I think that every cabinet member and his wife was there. And the wives were all honorary members of the campaign.

And after dinner, the Cabinet members all went back and they cut their budgets for the various programs that would help us have healthy babies right from the start, so to speak.

And our concern here is that we do have an opportunity. One of the things that this Committee has tried to focus on is where we get a match in good public policy and good economics.

We have identified a number of areas. Obviously, the areas that you're familiar with are prenatal care and maternal and child health care. All of the studies by every administration, by the foundations, by the universities, by the hospitals, the medical associations and others, all of them indicate that it's real good economics.

As you point out, this $2 billion is really being misspent. It's not being wasted, but it's being misspent in terms of the results that we want. And, as I think you heard here this morning, there is a better way to spend that money.

One of the things that concerns me is exactly what Mr. Sikorski pointed out. If you want to spend money, the pejorative term jumps in here that you're throwing money at a problem.

The fact of the matter is there's no reason why the Surgeon General or the Department of Health and Human Services cannot tell states that it is a condition of receiving money or it is your intent that they will not receive money.

Give them a year. Tell them you want one-stop shopping now. We can do that. We have the capability of doing that. And, theoretically, it won't cost us a dime.

If the states come back and tell us they can't do it for budgetary reasons, then we'll know that. The concerns that Mr. Bliley has and that the staff uncovered about coordination can be addressed by federal dollars which are driving the system overall.

Mr. **Bliley**. Mr. Chairman.

Chairman **Miller**. And we already have the capability to do that. And I think what we're hungry for is a sense of initiative and urgency about these babies and about these women and about these families.

You know, if necessary, we're fully prepared to do it. We've done it when I was a member of the Budget Committee. We can change those priorities and engage in initiatives which result in savings.

We've done that before. We've made those cuts. And they've come along.

Mr. **Bliley**. Will the Chairman yield?

Chairman **Miller**. One second.

And so I think there really is an opportunity, and I want to thank you for your candor. I want to thank you for your attitude. And I just hope, it becomes part of the policy of this government.

Forget Administration *or* Congress. We've both lagged here a little bit.

That is the question because one of the things we've found in this room is that when we put these issues to a vote on a bipartisan basis, there has been support for these early initiatives.

But what has happened historically is we've been knocked down because the Administration did not want to seek the expenditure of those monies the Republicans and Democrats voted on. They voted because the case has been made that that is an investment and we're going to get a return on it as opposed to the $2 billion expenditure, which is a questionable rate of return in terms of the long-term health of these families and these children.

I yield to Mr. Bliley.

Mr. **Bliley**. I thank you, Mr. Chairman.

And, Dr. Mason, I, too, want to thank you for your candor and appearance here this morning. I would hope that you would look at

HR 2881, which I have introduced, which is the consolidated Maternal and Child Health Services Act for, if that becomes law, it would call for $7.2 billion, almost $7.3 billion, concentrated in one-stop shopping. And it wouldn't be any new money.

It would coordinate the $5.5 billion that the federal government has spread over 10 programs or so. And it would take the $1.7 billion that the states are currently spending, put it all together and have one-stop shopping.

And I don't think we'd need a lot more money. We may need some, but I wouldn't think we'd need a great deal to do the job.

So I would hope you would look at it.

Dr. **Mason**. We'll look at it very carefully.

Chairman **Miller**. If I might, I think it's important that you look at some of these initiatives that members are supporting who, like Mr. Bliley, have spent a great deal of time on.

The other thing is: We're talking about saving babies 10,000 out of 40,000. And let's not pretend, all of a sudden, that those 10,000 have become the crack and the AIDS babies.

Because, at least in the area that I represent, on the Indian reservations that I have visited, and the areas in the upper Midwest that I have visited, hospitals, public health clinics, and others have an identifiable population within their catchment area of people who need these services, but they are unable to extend those services to them.

So we can get to work on this population very quickly before we get into the complications of AIDS and crack and all of the other attendant problems.

This population, can be dramatically whittled down with people who simply are not receiving services. And outreach, again, if the federal government wants the states and local governments to engage in outreach, all it has to do is say so.

But we're coming out of a 10-year period where outreach was not encouraged because outreach meant you had to spend dollars because once you find them, you have to serve them.

And so we want to reverse that trend. We're perfectly capable of doing that by administrative ruling should we decide to do that.

And if that runs into problems, I suspect that they can be cured by the Congress because there's bipartisan support for those efforts. And maybe that's how we find out where the most efficient expenditure of those dollars are.

Well, thank you again very much. And we look forward to continuing to work with you.

Next we will have a panel that will be made up of Pamela Robinson from Maternal-Child Advocacy Project at Wayne State University in Detroit; Dr. Ezra Davidson from King-Drew Medical Center in Los Angeles, who will be accompanied by Sarah Brown from the Institute of Medicine, Washington, DC; Dr. Joyce Thompson from the University of Pennsylvania School of Nursing from Philadelphia; Dr. Marilyn Poland, who is from Wayne State University again; and Dr. John Niles, who is from the Mayor's Advisory Board of Maternal and Child Health, Washington, DC.

Welcome to the Committee. Your formal statements will be placed in the record in their entirety. And I would like to encourage you to proceed in the manner in which you are most comfortable, and that includes the extent to which you would like to comment on what you heard between the committee and Dr. Mason. You should certainly feel free to comment on that should you so desire.

And, Pamela, we'll start with you.

STATEMENT OF PAMELA ROBINSON, MATERNAL-CHILD HEALTH ADVOCATE, MATERNAL-CHILD HEALTH ADVOCATE PROJECT, WAYNE STATE UNIVERSITY, DETROIT, MI

Ms. **Robinson**. Good morning. I'm Pamela Robinson from the Maternal-Child Health Project in Detroit. I have been an advocate since July of 1988. I became an advocate because I know that a helping hand and support made a positive impact in my own life.

The Maternal-Child Health Advocacy Project is one of several outreach programs funded by the Michigan Department of Public Health to fight the high infant mortality rate in 13 Michigan counties. Our long-range goal is to reduce infant mortality by improving pregnancy outcomes and the health of infants.

The services we offer are designed to increase the independence of families. They include assisting women to seek prenatal care and to use community resources.

In providing these services, we add tender, loving care that consists of a helping hand, a shoulder to lean on, and someone who listens.

Since January of 1987 we have provided case management advocate services to almost 2,000 families. Forty-six percent of our clients had problems with basic needs. These problems are barriers to getting health care and other needed services.

I would like to tell you about a client of mine who had many of these problems. Let's call my client Mary. When I began to work with her, Mary was 21 years old, 5 months pregnant, and had a 2 and a half year old son. Although she was enrolled in prenatal care and had Medicaid, she was not getting the care she needed.

Mary had recently been burned out of her apartment, lost all of her possessions, including her important papers and identification, and had to move in with her mother.

Her mother didn't have adequate housing for herself and her other children because six months earlier, she had been burned out also. With Mary and her son, there were seven people living in a two-bedroom house with no heat, borrowed electricity, and plumbing problems.

Mary was missing prenatal visits at this time because she had just lost her Medicaid. She was depressed and seemed to have no will and encouragement.

On the day I met Mary, I dealt with her main concerns, which were housing, food, and clothing. Over the next six weeks, we worked on housing, finances, and Medicaid. Only after these concerns were addressed was she able to resume her prenatal care.

Over the next few months, housing problems continued. Mary was also hospitalized for vaginal bleeding that began after a fall. She was released when she and the baby were out of danger.

She finally found suitable housing.

I am continuing to work with Mary and even though she still has some problems, she is more independent and persistent in dealing with these problems.

Other barriers to care are transportation and busy clinics. There are very few private physicians who will provide prenatal care. And our system of hospital and health department clinics cannot meet the demand.

For example, the average wait for the initial prenatal appointment in the clinic network is four weeks, and the waiting time in the clinics is usually several hours.

The health of families does not depend on doctors and clinics alone. We must have adequate health care systems. However, as I have described, resources to meet basic needs are also essential to health. Without jobs, housing, food, and clothing, people will not seek health care services.

Thank you for the opportunity to speak with you today.

[Prepared statement of Pamela Robinson follows:]

Prepared Statement of Pamela Robinson, Material-Child Health Advocate Project, Detroit, MI

Good morning ladies and gentlemen. I am Pamela Robinson from the Maternal-Child Health Advocate Project in Detroit, Michigan. I have been with the project since July, 1988. I became an advocate because I wanted to help people. I know from experience that having help and support made a positive impact in my own life. By giving help and support to others, I hope to make a positive difference in their lives.

The Maternal-Child Health Advocate Project is one of several outreach programs funded by the Michigan Department of Public Health to combat the high infant mortality rates in 13 Michigan counties. We are based at Wayne State University. Our long range goal is to reduce infant mortality by improving pregnancy outcomes and the health of infants.

The services we offer are designed to increase the independence of families. They include home visits, assisting women to seek early and regular prenatal and infant health care, referrals for community resources and other social services, information about health, nutrition and parenting, and assistance with problem solving. In providing these services, we add a little TLC. Tender, loving care that consists of a helping hand, a shoulder to lean on and someone who listens.

Since our program began in January of 1987, we have provided advocate services to almost 2,000 families and have helped an additional 400 women register for prenatal care. To give you an idea of the difficulties families are faced with, of the first 1,064 clients enrolled in our program:

46% had problems obtaining clothing
40% had problems obtaining food
32% had problems obtaining insurance
23% had problems obtaining transportation
23% had emotional problems such as depression and anxiety

These problems are barriers that interfere with our clients ability to get health care and other needed services.

I would like to tell you about a client of mine who had many of these problems. Let's call my client Mary. I began to work with Mary in December of 1988. She was 21 years old, 5 months pregnant and had a 2 1/2 year old son. Although she was enrolled in prenatal care and had Medicaid, she was not getting the care she needed because of the many problems she was faced with.

Mary had recently been burned out of her apartment, lost all of her possessions including her important papers and identification, and had to move in with her mother. Her mother did not have adequate housing for herself and her other children because 6 months earlier she had also been burned out and was forced to move into poor housing. The first thing I noticed when I approached the house was the 2 steps missing from the entrance. With Mary and her son, there were now 7 people living in this 2 bedroom house. There was no heat, the electricity was borrowed from next door and there was a foul smell in the house due to plumbing problems. Mary was missing prenatal visits at this time because she was depressed, seemed to have no will, and had no encouragement because the whole family was overwhelmed by the housing situation.

On the day I met her, Mary stated her family needed food. I gave her a referral for emergency food and enrolled her in a food co-op and a supplemental food program. We then began to work on replacing the clothing she had lost in the fire. She needed clothing so that she could get out and begin to get her life back in order. Over the next 4 to 6 weeks we worked on housing and getting her finances and Medicaid in order. During that time we also talked about the importance of prenatal care. Mary followed through by making and keeping a prenatal appointment. The help and support I was able to give her made a difference in her ability to act on her problems.

In February of 1989, the family experienced a third house fire and possessions were lost again. Mary then was forced to live with a friend for several months. During that time she fell, injured herself and began to have vaginal bleeding. She did not seek emergency treatment until I encouraged her to do so. When she went to the doctor, Mary was hospitalized for a week. She was released when the doctors felt she and the baby were out of danger.

Mary finally found suitable housing in April, only 3 weeks before she delivered a healthy 6 lb., 15 oz. baby girl. I am continuing to work with Mary. Even though she still has some problems, she is more independent and persistent in dealing with those problems now.

Transportation is also a problem for families. Even though we do have some transportation services in Detroit, including the Healthy Baby Service, they are not adequate to meet the needs.

Another barrier to obtaining needed health services is an inadequate system capacity. There are very few private physicians in Detroit who provide prenatal care. The system of hospital and health department clinics that is in place cannot meet the demand. For example, the average wait to get an initial prenatal appointment in the Maternal-Child Health Network is 4 - 6 weeks. In addition, the waiting time in the clinic itself is usually several hours.

The health of families does not depend on doctors and health facilities alone. We must have adequate health care systems. However, as I have described, resources to meet basic needs are also essential to health. Without jobs, housing, food and clothing, people will not seek health care services. Measures to promote healthy families must be comprehensive and coordinated across disciplines, agencies and departments.

Thank you for the opportunity to speak with you today.

Chairman **Miller**. Thank you.

Dr. Davidson, you can move that microphone a little bit closer. Thank you.

STATEMENT OF EZRA C. DAVIDSON, JR., M.D., MEMBER, COMMITTEE TO STUDY OUTREACH FOR PRENATAL CARE, INSTITUTE OF MEDICINE, PROFESSOR AND CHAIRMAN, DEPARTMENT OF OSTETRICS AND GYNECOLOGY, KING-DREW MEDICAL CENTER, LOS ANGELES, CA, ACCOMPANIED BY SARAH S. BROWN, STUDY DIRECTOR, COMMITTEE TO STUDY OUTREACH FOR PRENATAL CARE, INSTITUTE OF MEDICINE, WASHINGTON, DC

Dr. **Davidson**. Thank you. I want to compliment the Committee on focusing its attention to these issues. I think it's quite important.

My name is Ezra C. Davidson, Jr. I'm professor and Chairman of the Department of Obstetrics and Gynecology at the University of Medicine and Science in the King-Drew Medical Center in Los Angeles.

I served as a member of the Institute of Medicine Committee to Study Outreach for Prenatal Care, which produced the report "Prenatal Care: Reaching Mothers and Reaching Infants."

I understand that I was invited to testify today based upon my personal experience as a member of the IOM panel and my professional experience of the problem of delivering maternity care to low-income women on a day-to-day basis in Los Angeles.

I have included the exact text of the conclusions and major recommendations from the Committee. I do not believe that they could be better or more succinctly stated.

I do want to emphasize one major point from our conclusions. We learned that things are really terrible out there in regards to maternity health service. And they are so terrible that the congressional penchant for incremental changes will not fix this problem.

Expanding Medicaid alone, adding home visiting alone, supporting nurse midwives alone, increasing reimbursement alone, nothing alone will solve the problems. There must be major fundamental change in the ways we finance and deliver care for low-income women.

The Committee grouped the barriers to prenatal care into four categories—most of this is not new—one, financial and administrative barriers for women, which range from problems with private insurance to problems with Medicaid coverage to no insurance coverage at all; second, inadequate capacity in the prenatal care system; third, problems in the organization, practices, and atmosphere of prenatal services themselves; and, fourth, cultural and personal factors that limit the use of services.

I think that if the Committee were meeting today, rather than in 1985, as we did, it would add crack cocaine as a fifth barrier. The situation that develops when drugs such as this are added to pregnancy is so devastating that it deserves its own place on the list.

The financial system that currently supports maternity services for poor women in many communities is primarily Medicaid. In the past few years much has been done to expand eligibility for Medicaid and to split this program from the traditional association with cash assistance to dependent children.

Much of this activity has been helpful as a positive response to the concern about the financial barriers to prenatal care, those barriers mentioned most often by pregnant women.

However, the same attention has not been paid to the provider side of the service equation. The capacity to provide maternity services to the women who have become eligible under the expansions of Medicaid, or those who are still uninsured, is woefully inadequate.

The government has ignored or underestimated the incentives required to ensure an adequate number of providers needed to serve poor women: adequate and fair reimbursement, and equally, if not more, important, streamlining the payment mechanisms, which in the Medicaid administration are so frustrating and in themselves costly.

Specific attention must be given to reducing the uncertainty and complexity of Medicaid for the physician, including: the determination of patient eligibility and duration of eligibility, inadequate coverage for services needed by women with high risk pregnancies; complexity and unnecessary delays in billing; and the difficulties and loss of time required to redress these billing problems.

The government has ignored or underestimated the incentives required to ensure an adequate number of providers needed to serve poor women. Many of the changes are administrative, rather than financial, that are needed.

One cannot address the issues of access without addressing the liability situation, which in some places created absolute barriers to care and in others exaggerated existing problems.

In my home state, for example, one of the insurance companies is threatening to deny insurance coverage for drop-in deliveries. This would create an absolute barrier to care.

The cost of liability coverage causes many physicians to drop obstetrics from their practice. In other cases, the costs make it harder to care for poor women because the additional services necessary to treat high risk pregnancies are not covered by Medicaid.

The common belief that physician non-participation is due only to inadequate funding and physician attitudes is unjustly incomplete. The system has burdens that it should share in this responsibility for lack of participation for providers, and more concern should be devoted to the provider concerns of reaching remedies.

In Los Angeles in the calendar year 1988 over 170,000 births occurred in Los Angeles County. This represents 34 percent of the births in the State of California and 4.3 percent, or 1 out of every 23, of those in the nation as a whole.

Of the total births in the county 44,000, or 26 percent, represent women who sought maternity services from public sector facilities; that is, clinics and hospitals operated by the County Department of Health Services. This is approximately 28 percent more than the 34,900 birth capacity of this system.

Since the early 1980s the Los Angeles Department of Health Services has attempted to meet the increased demand for maternity services through a variety of mechanisms, including contracting with private hospitals and private physicians to accommodate this patient load.

Unfortunately, provider participation, both hospitals and physicians, in the Medicaid program has so deteriorated during the decade of the '80s that access to needed health services remains severely limited in this private sector.

The failure of Medicaid reimbursement levels to keep up with escalating costs combines with the incessant, ubiquitous complaints related to non-timely payment of billings, complicated and burdensome billing and payment systems, arbitrary denials of requests for prior authorizations, legal liability concerns.

And exorbitant malpractice insurance premiums has driven most hospitals and practitioners out of the Medi-Cal Program and left them with such a bitter taste in their mouths that even recent attempts to increase the reimbursement levels and improve the claims processing system have not been successful in inducing sufficient numbers of providers back into the program.

Consequently, access to care remains a rapidly deteriorating problem for low-income women in Los Angeles today.

In the King-Drew Medical Center, which is a county hospital, part of the Los Angeles Department of Health Services, the Department of Obstetrics provides delivery services to over 8,000 poor women each year. It is the second largest service in the State of California and the seventh largest in the country.

Eighty percent of the obstetric patients were Hispanic and 15 percent were black last year. These percentages have remained essentially unchanged for the last 10 years.

Participation in prenatal care has seriously deteriorated since 1978. In that year, eight percent of the women who delivered at the King-Drew Center reported no or unknown prenatal care. By 1988 this group had grown to 33 percent.

Significant racial and ethnic differences exist between those who do and do not have prenatal care, both for the black and Hispanic women.

Among black women, the percentage who have not had care has increased from 30 percent to 50 percent in the past 5 years. Among Hispanic women, the percentage has almost doubled, increasing from 15 to 27 percent over the same period.

The significance of not receiving care can be seen on the impact on the perinatal mortality, which are fetai and newborn lives lost. Seventy percent of the perinatal mortality comes from this group of not receiving prenatal care, as do most of the babies that end up in our high tech, high cost Neonatal Intensive Care Unit.

In my testimony, I have appended several graphs and charts describing these data in more detail.

Finally, I think that the recommendations in the Institute of Medicine report "Prenatal Care: Reaching Mothers, Reaching Infants" deserve detailed attention for guiding reform of the maternity care system. I think that ultimately the services must be organized and administered from the point of view of the pregnant patient.

Eligibility determination and registration must be simple and understandable. The administration of services should be plain and straightforward.

Other necessary services should be easily accessible and available, such as other necessary medical services for high risk pregnancies, supplemental food program, WIC, infant care services, educational and psychosocial support services. It is my personal opinion that this can be accomplished in both the private and public parts of this medical system.

Of extreme importance is having serious respect for the concerns of the providers. This calls for program administration with a resolve to be user friendly, reacting with support to the problems of eligibility, administration, and reimbursement.

Importantly, in this time of budget constraints, providing prenatal care services has been provided to reduce overall cost.

Continuing to incrementally expand eligibility and coverage, even with increased reimbursement, is clearly not enough. Reform of the administration of these services to invite better participation of providers and patients is necessary.

The medical liability crisis must be moderated. I personally support the recommendations in the recently released Institute of Medicine report "Medical Professional Liability and the Delivery of Obstetrical Care." This report recognizes the increasing impact of the liability problem on the availability of obstetric care and the impelling needs for reforms.

I appreciate the opportunity to appear before this Committee, Mr. Chairman.

[Prepared statement of Dr. Ezra C. Davidson, Jr. follows:]

Prepared Statement of Ezra C. Davidson, Jr., M.D., Professor and Chairman, Department of Obstetrics and Gynecology, Drew University of Medical Science, and King-Drew Medical Center, and Professor, Department of Obstetrics and Gynecology, University of California at Los Angeles, Los Angeles, CA

My name is Ezra C. Davidson, Jr. MD. I am Professor and Chairman of the Department of Obstetrics and Gynecology at Drew University of Medical Science and King-Drew Medical Center in Los Angeles, California. I served as a member of the Institute of Medicine (IOM) Committee to Study Outreach for Prenatal Care which produced the report "Prenatal Care: Reaching Mothers, Reaching Infants." I understand that I was invited to testify today based upon my personal experience as a member of the IOM panel and my professional experience of the problems of delivering maternity care to low-income women on a day-to-day basis in Los Angeles.

The Institute of Medicine Report

The IOM Committee to Study Outreach for Prenatal Care was an interdisciplinary group, convened to study ways that more women could be drawn into early prenatal care and kept in care throughout their pregnancy. The committee was asked to focus on outreach as a method for increasing the use of prenatal care. But it was evident early in the study that outreach could not be studied apart from the maternity care system in which it might occur.

The committee's investigations and its report covered a wide range of subjects, including: "demographic risk factors, the barriers to the use of prenatal care, women's perceptions of the barriers to care, provider's opinions about the factors that account for delayed care, multivariate analysis of predictors of prenatal care use, and lessons learned from a variety of programs that attempt to improve utilization of this basic health service."

I have included below the exact text of the conclusions and major recommendations from the committee. I do not believe that they could be better or more succinctly stated. I do want to emphasize one major point from our conclusions: We learned that things are really terrible out there. And, they are so terrible that the congressional penchant for incremental changes won't fix the problem. Expanding Medicaid alone, adding home visiting alone, supporting nurse midwives alone, increasing reimbursement alone, nothing alone will solve the problems. There must be major, fundamental change in the ways we finance and deliver care for low-income women.

The committee grouped the barriers to prenatal care into four categories: 1) financial and administrative barriers for women, which range from problems with private insurance to problems with Medicaid coverage to no insurance coverage at all; 2) inadequate capacity in the prenatal care system; 3) problems in the organization, practices, and atmosphere of prenatal services themselves, and 4) cultural and personal factors that limit the use of services. I think that if the committee were meeting today, rather than in 1985 as we did, it would add "crack" cocaine as a fifth barrier. The situation that develops when drugs take over a community is so devastating that it deserves its own place on the list.

I want to expand upon some aspects of these barriers as I describe for you the situation that we face in Los Angeles. Much of what I will include fits into the second category, inadequate capacity in the system, although it relates to the category of financial barriers, and as a result, to the third category of barriers, how services are organized and delivered, as well. Though there is a definite increase in the problems of access in rural areas, mainly due to physicians dropping obstetric care from their practices, I will focus my attention on the problems in urban areas.

The financial system that currently supports maternity services for poor women in many communities is primarily Medicaid. In the past few years much has been done to expand eligibility for Medicaid and to split this program from its traditional association with cash assistance for dependent children. Much of this activity has been helpful as a positive response to the concern about the financial barriers to prenatal care -- those barriers mentioned most often by pregnant women.

However, the same attention has not been paid to the provider side of the service equation. The capacity to provide maternity services to the women who have become eligible under the expansions of Medicaid, or those who are still uninsured, is woefully inadequate. The government has ignored or underestimated the incentives required to ensure an adequate number of providers needed to serve poor women: adequate and fair reimbursement, and equally, if not more, important, streamlining the payment mechanisms, which in the Medicaid administration are so frustrating and in themselves, costly. Specific attention must be given to reducing the uncertainty and complexity of Medicaid for the physician, including: the determination of patient eligibility and duration of eligibility, inadequate coverage for services needed by women with high risk pregnancies; complexity and unnecessary delays in billing; and the difficulties and loss of time required to redress these billing problems.

One cannot address the issues of access without addressing the liability situation which has in some places created absolute barriers to care and in others exacerbated existing problems. In my home state for example, one of the insurance companies is threatening to deny coverage for "drop-in" deliveries. This would create an absolute barrier to care. The costs of liability coverage cause many physicians to drop obstetrics from their practice. In other cases, the costs make it harder to care for poor women because the additional services necessary to treat high risk pregnancies are not covered by Medicaid.

Parenthetically, in one small effort regarding physician participation, there was Congressional support for authorization for demonstration projects under Medicaid designed to give states an opportunity to implement innovative ways to improve physician participation. It's my understanding that the Senate removed even this incremental effort from the reconciliation bill this month.

The above list is the briefest sketch of what must be endured by physicians to participate in the program. The common belief that physician non-participation is due only to inadequate funding and physician attitudes is unjustly incomplete. These system burdens share much of the responsibility for physicians' lack of participation and should be equally considered in remedies. As a result of these problems, fewer and fewer physicians and private hospitals provide obstetric services to Medicaid patients, and the public facilities, including the hospitals, that provide such services are so overloaded that they cannot meet the need. Medicaid is so underfunded and so bureaucratically impaired that services cannot be delivered in a fashion that even approaches adequate.

Additionally, the important new report, "Caring for the Future: The Content of Prenatal Care," issued by the Public Health Service calls for greatly expanded educational and psychosocial services for high risk patients. This report further documents how we are failing our pregnant women and children when we cannot even pay for the very basic and important medical services needed by these same women.

The Situation in Los Angeles

I would like to thank Irwin Silberman, MD, MS, Director of Maternal Health and Family Planning Programs, County of Los Angeles Department of Health Services for his assistance in providing some of the following data and perspectives from Los Angeles. However, I accept full responsibility for the editorial emphasis and final content.

In calendar year 1988, over 170.000 births occurred in Los Angeles County. This represents 34% of the births in the State of California, and 4.3%, or 1 out of every 23, of those in the nation as a whole. Of the total births in the county, 44,500 or 26%, represent women who sought maternity services from public sector facilities, i.e., the clinics and hospitals operated by the County Department of Health Services (DHS). This is approximately 28% more than the 34,900 births capacity of the DHS system.

Since the early 1980s, the Los Angeles Department of Health Services has attempted to meet the increased demand for maternity services through a variety of mechanisms. In addition to markedly increasing the total number of prenatal visits within the system, a special effort was directed toward reducing the waiting period for new appointments, i.e., entry into the system, down to a county-wide average of less than two weeks. This was accomplished between February and June 1989 by expanding the number of prenatal clinic intake sessions with newly added staffing resources plus shifting of personnel from other categorical public health programs and from follow-up/revisit prenatal clinics.

While this objective has been met, it has introduced the expected marked increase in the demand for routine, follow-up clinics, as well as a proportionate increase in referrals to the hospitals' already overburdened special obstetric and high risk prenatal clinics.

Recognizing that one of the major sources of the increase in service demand in Los Angeles County stemmed from the uncontrolled and unpredictable addition of undocumented immigrants to our communities, and the ever-growing numbers of uninsured and underinsured working poor, the California State Legislature responded in 1988 by passing legislation which provided Medi-Cal insurance coverage (Medicaid) to all financially qualified women for emergency and pregnancy-related services (SB 175, Maddy), and by increasing the income eligibility level to 185% of the federal poverty level (SB 2579, Bergenson-Roberti). The first measure took effect October 1, 1988, the latter, July 1, 1989.

Unfortunately, provider participation -- both hospitals and physicians -- in the Medi-Cal Program has so deteriorated during the decade of the eighties, that access to needed health care services for these newly eligible women remains severely limited in the private sector. The failure of Medi-Cal reimbursement levels to keep up with escalating costs, combined with the incessant and ubiquitous complaints related to non-timely payment of billings, complicated and burdensome billing and payment system, arbitrary denials of requests for prior authorizations, legal liability concerns, and exorbitant malpractice insurance premiums has driven most hospitals and practitioners out of the Medi-Cal Program, and left them with such a bitter taste in their mouths that even recent attempts to increase the reimbursement levels and improve the claims processing system have not been successful in inducing sufficient numbers of providers back into the program. Consequently, access to care remains a rapidly deteriorating problem for low-income women in the county.

At this time, Autumn of 1989, many communities in Southern California, and elsewhere in the state, find this situation approaching a flashpoint. Private hospitals in Southern California are unwilling and/or unable to accept additional publicly funded patients. The resources for expanding the availability of prenatal care in public sector facilities are fully expended. County hospitals and clinics are operating far beyond their safe and rational limits, with department heads frantically seeking means to prevent the unmanageable influx of high risk patients and trying to cope with the complement of overworked, disillusioned and disgruntled nursing and house staffs, and quality assurance and medico-legal liability concerns and consequences. One specific case dramatizes the situation for all: In Orange County, guards have been placed at the University of California at Irvine Medical Center to direct pregnant women who did not receive prenatal care in one of its clinics to other hospitals. This is not because the hospital does not want to take care of uninsured or undocumented patients. It is because the hospital is so over capacity they cannot safely provide services to additional women. (clipping attached)

No single source seems to have a satisfactory answer to these problems. The current consensus viewpoint in our area suggests that our efforts might be most effectively directed at influencing the state-level power structure to further liberalize the operational policies of the California Medical Assistance Commission (the independent, quasi-governmental body which is responsible for negotiating Medi-Cal contracts with hospitals) toward allowing non Medi-Cal hospitals in severely impacted areas to negotiate single-service obstetrical/neonatal contracts for the care of pregnant Medi-Cal beneficiaries and their newborn infants.

The basis for this position is a recent survey which revealed that in the absence of barriers related to inadequate reimbursement levels and other Medi-Cal operational impediments, there exists in Los Angeles County sufficient capacity in private hospitals to provide obstetrical services for as many as 2,000 additional patients monthly, more than enough to meet the needs of this community well into the twenty-first century. With the normally anticipated growth in hospital beds and numbers of providers in various categories, consistent with the projected growth in population, there is no reason to believe that, absent the barriers which we have discussed, Los Angeles County would not be able to meet its goals in providing adequate perinatal care to all of its needy residents.

Improvement in the cost reimbursement levels, reduction of paperwork, more timely claims processing and provider payment, and less stringent authorization regulations would go far toward attracting providers back into the system.

At the King-Drew Medical Center

The King-Drew Medical Center is a county hospital, part of the Los Angeles Department of Health Services. The Department of Obstetrics and Gynecology provides delivery services to over 8,000 poor women each year. It is the second largest service in the state of California and the seventh largest in the country. Eighty percent of the obstetric patients were Hispanic and 15% were Black in 1988. These percentages have remained essentially unchanged for the last 10 years. Participation in prenatal care has seriously deteriorated since 1978. In that year, 8% of the women who delivered at King-Drew reported no, or had unknown, prenatal care. By 1988 this group had grown to 33%. Significant racial and ethnic differences exist between those who do and do not have prenatal care, but for both Black and Hispanic women, the changes have been remarkable. Among Black women, the percentage who have not had care has increased from 30% to 50% in the past five years. Among Hispanic women, the percentage has almost doubled, increasing from 15% to 27% over the same period.

The significance of not receiving care can be seen in the impact on the perinatal mortality, which are fetal and newborn lives lost. Seventy percent of the perinatal mortality comes from the group not receiving prenatal care, as do most of the babies that end up in the high tech, high cost Neonatal Intensive Care Unit. I have appended several graphs and charts describing these data in more detail.

The reasons given by women in our population for not getting prenatal care are similar to those described in the Institute of Medicine Report. In a survey of patients done in 1986, 35% reported financial barriers, 25% reported transportation problems, 20% reported child care. These three groups of barriers account for about 80% of those with no or delayed prenatal care. Only about 10% reported that they did not think prenatal care was important, and another 10% reported other miscellaneous reasons.

Conclusions

I think that the recommendations of the Institute of Medicine report, "Prenatal Care: Reaching Mothers, Reaching Infants," deserve detailed attention for guiding reform of the maternity care system. I think that ultimately the services must be organized and administered from the point of view of the pregnant patient.

Eligibility determination and registration must be simple and understandable. The administration of services should be plain and straightforward. Other necessary services should be easily accessible and available, such as, other necessary medical services for high risk pregnancies, the Special Supplemental Food Program for Women, Infants and Children (WIC), infant care services, educational and psychosocial support services. It is my personal opinion that this can be accomplished in both the private and public parts of the system.

Of extreme importance is having serious respect for the concerns of providers. This calls for program administration with a resolve to be "user friendly," reacting with support to the problems of eligibility, administration and reimbursement.

I hope as a country we resolve to make the fundamental reforms that are required. We can continue to deny the obvious overall need by dealing with the problems on an incremental basis, and we may do some good things this way. Along that path, we may eventually reach the point where these reforms achieve a threshold level that demonstrates that continuation in this mode is not the most effective, and that we must take the last steps to the fundamental reform. Or, we can come to grips with the reality of what needs to be done, what is the right thing to do, now, and take care of the problem. Continuing to incrementally expand eligibility and coverage, even with increased reimbursement, is clearly not enough. Reform of the administration of these services to invite better participation of providers and patients is necessary.

Finally, the medical liability crisis must be moderated. I personally support the recommendations in the recently released Institute of Medicine Report "Medical Professional Liability and the Delivery of Obstetrical Care." This report recognizes the increasing impact of the liability problem on the availability of obstetric care and the impelling need for reforms.

CONCLUSIONS AND RECOMMENDATIONS FROM PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS

The data and program experience reviewed by the Committee reveal a maternity care system* that is fundamentally flawed, fragmented, and overly complex. Unlike many European nations, the United States has no direct, straightforward system for making maternity services easily accessible. Although well-insured, affluent women can be reasonably certain of receiving appropriate health care during pregnancy and childbirth, many women cannot share this expectation. Low-income women, women who are uninsured or underinsured, teenagers, inner-city and rural residents, certain minority groups, and other high-risk populations are likely to experience significant problems in obtaining necessary maternity services.

The committee concludes that in the long run, the best prospects for improving use of prenatal care-and reversing current declines-lie in reorganizing the nation's maternity care system. Although a new system may include some elements of the existing one, the Committee specifically recommends against the current practice of making incremental changes in programs already in place. Instead, it argues for fundamental reform. Several ways are available for designing the specific components of a new system, but no such work should proceed until the nation's leaders first make a commitment to enact substantial changes. A deeper commitment to family planning services and education should accompany improvements in the maternity care system.

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*That is, the complicated network of publicly and privately financed services through which women obtain prenatal, labor and delivery, and postpartum care.

In the short term, the Committee urges strengthening existing systems through which women secure prenatal services. This includes simultaneous actions to:

1. remove financial barriers to care;
2. make certain that basic system capacity is adequate for all women;
3. improve the policies and practices that shape prenatal services at the delivery site; and
4. increase public information and education about prenatal care.

Federal leadership of this four-part program is essential, supplemented by state action to ensure the availability of prenatal services to all residents.

Even if all four system changes were implemented, however, there would still be some women without sufficient care because of extreme social isolation, youth, fear or denial, drug addiction, cultural factors or other reasons. For these women, there is a clear need for casefinding and social support to locate and enroll them in prenatal services and to encourage continuation in care once begun. These outreach services, supplementing a well-designed, highly accessible system of prenatal services, can help draw the most hard-to-reach women into care.

Unfortunately, though, outreach is often undertaken without first making certain that the basic maternity care system is accessible and responsive to women's needs. Too often, communities organize outreach to help women over and around major obstacles to care rather than removing the obstacles themselves. To fund outreach in isolation and hope that it alone will accomplish major improvements in the use of prenatal services is naive and wasteful.

In support of this general view, the Committee makes a number of recommendations regarding program management, evaluation, and research. The Committee concludes that not all programs should have to muster the funds and expertise to conduct formal evaluation studies. For those that choose to do so, a higher quality of effort is needed than that exhibited by most of the programs reviewed. With regard to research, the Committee specifically urges that no more research be conducted to demonstrate the importance of financial and other institutional barriers to care. The Committee does, however, suggest six specific research topics (see recommendation 14 below) and recommends that the current practice of securing funds for services under the guise of research cease.

SPECIFIC RECOMMENDATIONS

The full report includes 14 major recommendations; most have one or more subsidiary recommendations not included in this brief summary.

1. We recommend that the nation adopt as a new social norm the principle that all pregnant women-not only the affluent-should be provided access to prenatal, labor and delivery, and postpartum services appropriate to their need. Actions in all sectors of society, and clear leadership from the public sector especially, will be required for this principle to become a clear, explicit, and widely shared value.

2. We recommend that the President, members of Congress, and other national leaders in both the public and private sectors commit themselves openly and unequivocally to designing a new maternity care system-or systems-dedicated to drawing all women into prenatal care and providing them with an appropriate array of health and social services throughout pregnancy, childbirth, and the postpartum period. Although a new system might build on existing arrangements, long-term solutions require fundamental reforms, not incremental changes in existing programs.

3. We recommend that more immediate efforts to increase participation in prenatal care emphasize four goals: eliminating financial barriers to care, making certain that the capacity of the maternity care system is adequate, improving the policies and practices that shape prenatal services at the site where they are provided, and increasing public information about prenatal care. (in recommendations 5 through 8, each of these four goals is developed more fully).

4. We recommend that the federal government provide increased leadership, financial support, and incentives to help states and communities meet the four goals we advocate (recommendation 3). In parallel effort, states should accept responsibility for ensuring that prenatal care is genuinely available to all pregnant women in the state, relying on federal assistance as needed in meeting this responsibility.

5. We recommend that top priority be given to eliminating financial barriers to prenatal care. (More specific recommendations are directed toward Medicaid, the various federal grant programs, state and local health departments, and private insurance).

6. We recommend that public and private leaders designing policies to draw pregnant women into prenatal care make certain that services are plentiful enough in a community to enable all women to secure appointments within two weeks with providers close to their homes. (Numerous methods for achieving this goal are suggested).

7. We recommend that those responsible for providing prenatal services periodically review and revise office or clinic procedures to make certain that access is easy and prompt, bureaucratic requirements minimal, and the

atmosphere welcoming. Equally important, services should be provided to encourage women to continue care. Follow-up of missed appointments should be routine, and additional social supports should be available where needed. (Many suggestions are made to improve institutional practices at the delivery site).

8. We recommend that public and private groups-government, foundations, health services agencies, professional societies, and others-invest in a long-term, high quality public information campaign to educate Americans about the importance of prenatal care for healthy mothers and infants and the need to begin such care early in pregnancy. The campaign should carry its message to schools, the media, family planning and other health care settings, social service networks, and places of employment. Additional campaigns should be aimed at the groups at highest risk for insufficient care. Whether directed at the entire population or a specific subgroup, public information campaigns should always include specific instructions on where to go or whom to call to arrange for prenatal services.

9. We recommend that initiatives to increase use of prenatal care not rely on casefinding and social support to correct the major financial and institutional barriers that currently impede access. Rather, outreach should be only one component of a well-designed, well-functioning system and should be targeted toward women who remain unserved despite easily accessible services. Outreach should only be funded when it is linked to a highly accessible system of prenatal services, or, at a minimum, when it is part of a comprehensive plan to strengthen the system, emphasizing the four areas previously described.

10. We recommend that in communities where financial and institutional barriers have been removed, or as part of a comprehensive plan to do so, at least five kinds of casefinding be considered for their compatibility with a program's goal and constraints: (a) telephone hotline and referral services that can make prenatal appointments during the initial call and can provide assistance to callers in arranging needed maternity, health, and social services; (b) television and, in particular, radio spots to announce specific services, coordinated with posters displayed in the mass transit system; (c) efforts to encourage current program participants to recruit additional participants from their friends, neighbors, and relative; (d) strong referral ties between prenatal programs and a variety of other systems in which pregnant women at risk for insufficient care may be found: family planning clinics, schools, housing programs, WIC agencies, welfare and unemployment offices, churches and community service groups, shelters for the homeless, the police and corrections systems, substance-abuse programs and treatment centers, and other health and social service networks; and (e) outreach workers who canvass in carefully defined target areas and seek clients among well-defined target populations. Whatever the method used, casefinding should be directed toward high-risk groups and areas. This requires that program leaders pinpoint the sociodemographic characteristics and geographic locations of women who obtain insufficient prenatal care.

11 We recommend that programs providing prenatal services to high-risk, often low-income groups include social support services to help maintain participation in care and arrange for additional services as needed. Home visiting is an important form of social support and should be available in programs caring for high-risk women.

12. We recommend that programs to improve participation in prenatal care invest generously in planning and needs assessment. Doing so will require a deeper appreciation, among funders in particular, of the time needed for responsible, intelligent program design and planning. Substantial improvements in the use of prenatal care (or in other measures of outcome such as low birthweight or infant mortality) should not be expected too soon.

13. We recommend that early in a program's course its directors decide whether it is to be primarily a service program (with data collected mainly to help in program development and monitoring) or whether it is also to test an idea in the field. The latter type requires ample funding if the evaluation is to be sound; it also requires experts in program evaluation and sophisticated systems for data collection-resources that must be built into the program from the outset.

14. We recommend that in communities where financial and institutional obstacles to care have been significantly lowered, research be undertaken on several topics: (a) Why do some pregnant women register late-or not at all-for prenatal care, even when financial and institutional barriers are ostensibly absent? In particular, what are the emotional and attitudinal factors that limit participation in care? (b) How can the content of prenatal care be revised to encourage women to seek such care early in pregnancy? (c) What casefinding techniques are most helpful in identifying very high-risk groups (such as low-income multiparous teenagers) and linking them to prenatal services? (d) What are the costs associated with various forms of casefinding and social support? (e) What are the most effective ways to forge links between physicians in private practice and community agencies providing the ancillary health and social services that high-risk women often need? and (f) How is access to maternity services being affected by such

recent developments as the decreased ability of hospitals to finance care for indigent patients through cost shifting, the increase in corporate ownership of hospitals, the gradual expansion of the DRG (diagnosis-related groups) system beyond the Medicare program, and the increasing profit orientation of the health care sector generally?

Hospital's Controversial Policy Hits Poor Immigrants

Women in Labor, Mostly Hispanic, Are Diverted From Crowded California Facility

By Patrick Whalen
Special to The Washington Post

ORANGE, Calif. —In a significant sign of continuing adversity for illegal immigrants, an overcrowded hospital here has posted security guards to divert mostly poor Hispanic women in labor to other hospitals' maternity wards.

The controversial "obstetrical diversion" policy at the University of California at Irvine (UCI) Medical Center comes on the heels of an academic report that says the Immigration Reform and Control Act of 1986 is failing.

State officials said the diversion, which state health authorities declared legal, also has illuminated a California health-care system in disarray.

The two-year immigration study by the UC-San Diego Center for U.S.-Mexican Studies said Mexican migration northward has not slowed since the act took effect.

The researchers reported that 41 percent of Mexicans interviewed for the study said they used false or borrowed documents to gain employment. The study also said the law caused "widespread fear" in Mexican communities that the "door was closing," causing whole families to enter the United States.

Half of the nation's illegals are in California, and 47.3 percent of all Mexican immigrants are there, the study said.

Delivery rates at UCI Medical ated by the University of California, skyrocketed from an average of 350 a month in 1987 to more than 500 a month this year, more than twice the number for which the maternity ward is designed, officials said. Last month's total was 558.

About 80 percent of women delivering at the hospital are indigent, and the vast majority are Hispanics who had no prenatal care, officials said.

"When you talk to these [women giving birth], you know darn well they are not" naturalized, said Dr. Thomas J. Garite, acting chairman of obstetrics and gynecology at UCI, who implemented the diversion policy in May with the blessing of university attorneys.

The high volume of deliveries created circumstances that hospital officials said were unsafe, including overcrowding that forced some women to undergo labor in hallways.

The official also reported that between 30 percent and 40 percent of Caesarean births at the hospital were accompanied by infection, which they blamed on the overcrowding. An acceptable rate of infection is about 15 percent, they said.

Hispanics accounted for more than one-third of Orange County's 38,730 births in 1987. Hispanics currently comprise 15.7 percent of the county's population, and that number is expected to exceed 20 percent when the 1990 census is released, officials said.

that California is home to 5.9 million Hispanics, nearly one third of the total in the United States. Birth rates and immigration pushed the Hispanic population from 14.3 million in 1980 to 17.5 million in 1985, accounting for almost one-fourth of the nation's population growth in the first half of the decade.

The Immigration and Naturalization Service has termed the immigration-reform law successful, citing declining arrests of illegals along the Mexican border.

Irene Riley, an administrator in the Los Angeles County Department of Health Services, cited the reform law as partially responsible for the decreasing percentage of illegal-alien births in the county from a high of 71 percent in 1986 to the current 55 percent.

The UC-San Diego researchers concluded, however, that, "given the gaping loopholes in the legislation itself and barring a truly massive increase in federal government resources dedicated to enforcing it, it is difficult to see how such a law can achieve the gradual, overall reduction in illegal immigration that its proponents promised."

Meanwhile, many hospitals statewide have cut services or closed because of mounting losses. Large numbers of patients cannot pay for service, and local governments have not stepped forward to reimburse hospitals for expanding health-care costs.

Nine of 24 Los Angeles County trauma centers have dropped out of the area's trauma-center network since 1985. In Orange County, four hospitals have quit contracts with Medi-Cal, the state-funded health-care program for the indigent. Hospitals have protested an average Medi-Cal reimbursement rate of 67 percent of bills accumulated by indigents.

The UCI Medical Center's policy "is really indicative of every problem facing health care in California," said Gail Catlin, a spokeswoman for the California Association of Hospitals and Health Services, a lobbying group representing about 85 percent of state hospitals. "Hospitals are being asked to operate in a way that no business could stand to operate in."

Catlin said California state hospitals provided $2.7 billion in uncompensated care last year, with 53 percent operating at a loss. In Los Angeles County, officials said, three of five patients could not pay for emergency-room treatment.

At the request of Gov. George Deukmejian (R), the state legislature has allocated $259 million of the state's $2.5 billion budget surplus to hospitals to pay indigent care bills, a spokesman said.

UCI obstetrics chief Garite dismissed charges that the diversion policy was discriminatory. "It doesn't matter if you're Mrs. John D. Rockefeller or Mrs. Rodriguez," he said. "It doesn't matter. You're not getting service if we're overfull."

Officials said that one of the two women turned away was in the eighth month of pregnancy and mistakenly thought she was in labor. Both sought and received help elsewhere, they said.

Women who have had prenatal care at the hospital are admitted even if the maternity ward is full, Garite said, stressing that the policy mainly affects women who "come in off the street."

The diversion policy is unusual because it is extremely rare for a hospital to divert patients from obstetrical care and to use guards to discourage people from entering, a spokeswoman for the American Hospital Association said.

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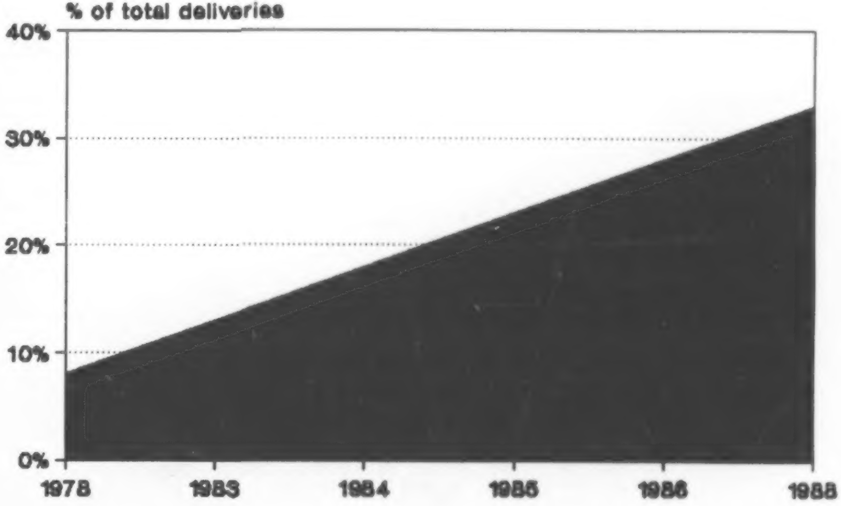
King-Drew Medical Center

No Prenatal Care



King-Drew Medical Center

Perinatal Mortality

1984-1986 (2 Years)

RACE = BLACK

	Perinatal Care at King-Drew System	None/Unknown Care		
		Expected	Observed	Signif.
N	1093	--	543	--
Stillbirths	10	8	26	*
Neonatal Deaths	8	7	21	*
Perinatal Deaths	18	15	47	*
Low Birth Weight	147	122	276	*
Very Low BW	25	21	83	*

Expected = Predicted occurance, if the rates were the same as those found in the King-Drew population

Observed = Actual occurance

* = Statistical significance between expected and observed

King-Drew Medical Center

Perinatal Mortality

1984-1986 (2 Years)

RACE = HISPANIC

	Perinatal Care at King-Drew System	None/Unknown Care		
		Expected	Observed	Signf.
N	2294	--	543	--
Stillbirths	8	2	6	NS
Neonatal Deaths	2	.5	1	NS
Perinatal Deaths	10	2.5	7	*
Low Birth Weight	105	25	50	*
Very Low BW	9	2	11	*

Expected = Predicted occurance, if the rates were the same as those found in the King-Drew population

Observed = Actual occurance

* = Statistical significance between expected and observed

Chairman MILLER. Thank you very much.

Next we'll hear from Dr. Thompson.

STATEMENT OF JOYCE E. THOMPSON, CNM, DPH, FAAN, MEMBER, PUBLIC HEALTH SERVICE EXPERT PANEL ON THE CONTENT OF PRENATAL CARE; PRESIDENT, AMERICAN COLLEGE OF NURSE MIDWIVES; PROFESSOR AND DIRECTOR, GRADUATE PROGRAM IN NURSE-MIDWIFERY, UNIVERSITY OF PENNSYLVANIA SCHOOL OF NURSING, PHILADELPHIA, PA

Ms. THOMPSON. Thank you, Mr. Chairman. My name is Joyce Beebe Thompson. I am a certified nurse-midwife and professor and Director of the Graduate Program in Nurse-Midwifery at the University of Pennsylvania School of Nursing.

I believe the main reason I was asked to testify this morning was because I was the chair of the psychosocial content of prenatal care on the recent Public Health Service Expert Panel on the Content of Prenatal Care and will be giving you just a brief review of the recommendations that pertained to psychosocial content that were in the publication on "Caring for Our Future."

I would like to respond very briefly to Dr. Mason earlier and to compliment this Committee for the recommendation that prenatal care is not a unitary construct in which medical intervention only makes a difference. It involves a lot more than what we do in terms of risk assessment and traditional technology in medical intervention.

And that is why, I believe, the Expert Panel on the Content of Prenatal Care endorsed four recommendations I'm going to talk about very briefly.

Our directive as an expert panel was to reaffirm the science base and the value of prenatal care. And, indeed, I do believe we did accomplish that. The specific focus on the psychosocial aspects of prenatal care led to the conclusions that I will talk about: one, that we need to be broad in our objectives for prenatal care, that they go well beyond getting women into prenatal care and delivering a healthy infant. And those objectives need to proceed at minimum to the first year of life of that child and that family.

Secondly, we focused on the appropriate use of both the psychosocial risk assessment and health promotion aspects of the prenatal care, trying to bring them into balance.

The psychosocial content that we particularly focused on dealt with risk assessment in the areas of smoking, alcohol, and other drug use, social support, stress levels, physical abuse and violence in the family and in the home environment, extremes of physical work and exercise, housing and finances, exposure to chemicals in the workplace, mental illness, and pregnancy readiness.

The interventions that we put forth, the recommendations for increased psychosocial intervention are: coverage for smoking cessation programs within the context of prenatal care, referral and coverage for alcohol and drug treatment programs, nutritional support expanded to not only the availability of counseling, but the increased availability of food supplementation on the basis of need, the use of home visits, home health agencies, social service referrals, safe shelters, and social support, things that we often have in a fragmented sense, but are not often coordinated within one prenatal care setting.

Health promotion is of particular interest, and our recommendations were to three general categories: counseling and education needed to promote and to support healthful behavior; general knowledge of pregnancy and parenting, including preparation for parenting skills; and information on proposed care, including the early entry into prenatal care at the point at which a woman conceives.

I think that probably one of the most significant recommendations of the expert panel was its statement that prenatal care must begin prior to conception in order to make a significant impact on the current infant mortality.

Stopping smoking, diminishing or eliminating drug abuse, avoiding exposure to chemicals can only be done in their most effective manner prior to the time a couple chooses to conceive.

I think, in summary, I will simply state that the prenatal care services, we also said, needed to be expanded. They need to be expanded in the areas of the psychosocial, both risk assessment and intervention. They need to be available, and they need to be used.

And I would suggest that the use of prenatal care services, even where they currently exist, if we were to eliminate all barriers, has to do with the need for public education on the value of care during pregnancy and in the process of the availability of services which aren't currently being used.

Dr. Davidson spoke to many of those barriers, as did the report he referred to in terms of services that are either incomplete, long waiting lists, or when the women actually get into the services, they aren't cared about.

And I think that one of the values of the expert panel's review of the content of prenatal care and the reaffirmation of its value is that we need to truly care about the women who are coming for the services, which may go much beyond the traditional medical services that we have given in the past.

I'd like to also take this opportunity, in summary, to support, as Dr. Davidson did, the recent Institute of Medicine study on liability insurance and its availability and support the recommendations in my role as President, American College of Nurse Midwives.

Thank you.

[Prepared statement of Joyce E. Thompson follows:]

PREPARED STATEMENT OF JOYCE E. THOMPSON, CNM, DPH, FAAN, MEMBER, PUBLIC HEALTH SERVICE EXPERT PANEL ON THE CONTENT OF PRENATAL CARE; PRESIDENT, AMERICAN COLLEGE OF NURSE MIDWIVES; PROFESSOR AND DIRECTOR, GRADUATE PROGRAM IN NURSE-MIDWIFERY, UNIVERSITY OF PENNSYLVANIA SCHOOL OF NURSING, PHILADELPHIA, PA

Mr. Chairman, my name is Joyce Beebe Thompson, CNM. I am a certified nurse-midwife, Professor and Director of the Graduate Program in Nurse-Midwifery at the University of Pennsylvania School of Nursing in Philadelphia, Pennsylvania. I have been in continuous nurse-midwifery practice since 1966 having worked in South Africa, New York, and Philadelphia. I have also served in the capacity of consultant in public health, maternal-child health, and nurse-midwifery. I recently served as the only nurse-midwife member of the Public Health Service Expert Panel on the Content of Prenatal Care. The report of that Panel was given on October 2, 1989, and much of my testimony will be based on the three years of work of that Panel examining the science base of specific prenatal activities. I chaired the half of the Panel responsible for the pyschosocial content of prenatal care.

The College appreciates the interest that the Committee has shown about the need of taking additional steps to combat infant mortality by improving access to prental care and other needed health care services for high-risk women and their babies.

NURSE-MIDWIFERY

A certified nurse-midwife (CNM) is a registered nurse with advanced education in midwifery who cares for women through their lives. This involves the provision of care for women and their newborns not only during pregnancy, childbirth, and the postpartum/neonatal period, but also includes family planning and gynecological services for women of all ages. CNMs work collaboratively with physicians with whom they consult and to whom they refer patients who develop complications that require physician care.

Much of the care provided by CNMs has always been directed at the needs of those women who have special problems in obtaining childbearing and other health services. Nurse-midwives are especially proud of their record in caring for pregnant women who are at risk for developing health problems because of various social and/or economic considerations. Pregnant teens in the inner-cities, young mothers in underserved rural areas of the country, Hispanic women in border States, native Americans on reservations, and minorities seeking help from clinics are all clients served by midwives in daily practice.

PRENATAL CARE AND NURSE-MIDWIVES

The value of prenatal care in helping our nation achieve its goal of healthier children who become productive adults has recently been addressed in detail by the Public Health Service Expert Panel on the Content of Prenatal Care. I would like to address four of this Panel's recommendations and briefly discuss how nurse-midwives have been and will continue to be important contributors to healthier families. The recommendations of interest today include: 1) Prenatal care consists of three basic components; early and continuous risk assessment, health promotion, and medical and psychosocial intervention and follow-up; 2) To ensure the health of the woman and the developing fetus, prenatal care needs to begin prior to conception (preconception); and 3) Prenatal care needs a renewed commitment to the psychosocial dimensions of that care, maintaining a balance with traditional medical concerns; and 4) Prenatal care must be available and used to be effective.

CONTENT OF PRENATAL CARE

For many years, the content of prenatal care defined by physicians has been heavily focused on risk assessment and medical intervention with laudable goals of making sure both the woman and infant were healthy. During this same time, nurse-midwives and public health nurses included much attention to the teaching and psychosocial dimensions of the woman's pregnancy and helping her and the family prepare for parenthood. More recently, studies about and by nurse-midwives have reinforced the importance of sharing knowledge about pregnancy, how to stay healthy, and how to be in control of one's total life in order to be healthier during pregnancy.

Public health officials have for many years stated that personal health habits, environments and socioeconomic status are the most important determinants of one's personal health. Prenatal care is an example of this truism. Health professionals cannot eat, sleep, exercise or avoid unhealthy or toxic substances for the pregnant woman. She must do that herself—and it takes knowledge, support and motivation to do so. Nurse-midwives are well suited to provide that knowledge in a supportive manner and to find out why some women cannot lead healthy lives. When recent studies highlighted poverty as a major determinant of low birthweight infants, prior studies of nurse-midwifery care became even more significant. Repeatedly in caring for low income women, whether living in rural or inner-city areas, nurse-midwives have demonstrated that the women in their care had healthier babies, and were healthier themselves than those women cared for by physician providers.

Corbett and Burst in South Carolina, Widhalm in New York City, and many others found that pregnant adolescents cared for by nurse-midwives had very good outcomes of pregnancy, including healthy babies. Some of the reasons for these healthy babies and women include the supportive way nurse-midwives interact with the adolescent, the knowledge about healthy behaviors they can share, and the eagerness the adolescents have for attending their prenatal visits, as one noted, "Because we know the nurse-midwife cares about us!"

PRECONCEPTION CARE

In spite of many efforts to improve the health outcomes for women and their babies in this country, many patients are not acutely aware that some activities need to begin before conception. Smoking, alcohol and drug abuse all result in unhealthy women and children. If these unhealthy habits are stopped before conception, healthy children can result. Transmission of venereal diseases, including HIV, can only be avoided if the couple are disease free outcomes of pregnancy, but many couples do not know how damaging their current lifestyles are. Preconception examination for risks for unhealthy children and counseling about healthy personal habits will have a great impact on healthier children for our nation.

Once again, the very nature of nurse-midwifery care has emphasized these aspects of risk assessment and health teaching for years. Nurse-midwives provide such care during family planning contacts, well-women health care, and for school children and church groups, when asked. We are educated as teachers as well as clinicians, we view the family and community as our clients, and we try to support women and couples as they make needed changes in their personal habits and lifestyles. We also work to promote teamwork with social workers, housing projects, dentists, physicians and other nurses, so that the total needs of childbearing families can be attended to—not just those the health care system can deal with effectively.

BALANCE OF CONTENT WITH PSYCHOSOCIAL EMPHASIS

The PHS Expert Panel on the Content of prenatal care placed much emphasis on the psychosocial dimensions of that care. These dimensions include both assessment for risk and intervention to improve the health and well-being of women and their infants. The Panel looked at risks for unhealthy behavior and lifestyle and recommended programs of home visits, smoking cessations, and drug counseling. Panel Members looked at risks related to poverty and suggested comprehensive, coordinated services included financial, housing, education as well as traditional medical support. We looked at the effects of high levels of maternal anxiety and stress and suggested more study of the positive effects of building and/or supporting the networks of friends, families and professionals for the pregnant woman and her family. The Panel suggested screening for family violence and safe shelters as well as education for parenting skills.

Once again, nurse-midwives have been on the forefront of providing these psychosocial interventions, building a long tradition in public health nursing. As the Office of Technology Assessment (OTA) noted in one of its reports to Congress, CNMs provide effective and low-cost maternity care to underserved, socioeconomically high-risk pregnant women and adolescents. And the Institute of Medicine (IOM) has recommended that more reliance be placed on nurse-midwives to increase access to prenatal care for hard-to-reach, often high risks groups.

ACCESS AND USE OF PRENATAL CARE

Several studies of nurse-midwifery care during pregnancy have resulted in similar findings related to access and women's of prenatal care services. The 1988 OTA report noted that "Historically, . . . CNMs have been credited with improving the geographic distribution of care, because many of us have been willing to locate in underserved rural and inner-city areas. CNMs increase access to primary care in a wide variety of nongeographic settings and for populations not adequately served by physicians. Using CNMs rather than physicians to provide certain services would appear to be cost-effective from a societal prospective."

Other studies of nurse-midwifery care reinforce that women seeking family planning or prenatal and post partum care from CNMs keep their scheduled visits and visit more frequently than those women cared for by physicians—especially the low-income women targeted by the Expert Panel as needed more visits and enhanced psychosocial services. Nurse-midwives have over 60 years history of providing this type of enhanced care for low-income, poorly educated women and families—and doing it with successful results.

Nevertheless, Mr. Chairman, important financial and other barriers to prenatal and maternity care still remain serious impediments for serving many low-income, high risk women and their new borns.

It is the expressed policy of the American College of Nurse-Midwives that all Americans should have some form of comprehensive health benefit coverage, including adequate protection against the costs of health care needed by mothers and their children during and after pregnancy and during early childhood as well. Obviously, we recognize that the problems of the uninsured and underinsured extend well beyond the care needs of women and infants. But, until the needs of these women and children are addressed, steps to effectively combat infant mortality in America will always be impaired. Congressional efforts to expand Medicaid eligibility requirements for low-income women and children as one important requirements for low-income women and children as one important way to improve access to prenatal and maternity care. We have been especially encouraged about recent legislation that makes it possible for States to greatly enhance Medicaid eligibility for these particularly vulnerable individuals. Nevertheless, the College believes that other actions are also needed, if access to needed care is to be assured.

One of these steps, which was recommended by the National Commission to Prevent Infant Mortality, calls for an increase in the numbers of health care providers, willing and able to serve the needs of low-income women who are at greater than average risk for their pregnancies. Expanded eligibility for needed care alone will not assure that all those with the need for services before, during and after pregnancy can actually find providers who are able to help them.

For example, just a few days ago, the Institute of Medicine (IOM) of the National Academy of Sciences released its report on problems with the availability of obstetrical care in the United States stemming from malpractice litigation and liability insurance costs. The report documents the large number of obstetricians, family practitioners and certified nurse-midwives "leaving, or limiting, their practices in order to avoid the threat of litigation." The IOM report urges a variety of responses by the States on these issues, and calls on the Federal Government to support demonstration projects that would test innovative approaches to the professional liability problem.

The College also believes that something must be done to address the adequacy of current payment levels for services now provided to low-income and other uninsured individuals. For example, Mr. Chairman, many Medicaid programs have a long history of generally low payment rates for practitioner services in general, and especially for important primary care services. One Subcommittee in the House of Representatives that has looked in detail at this problem reports that, on average, Medicaid payment rates are only about two-thirds of the Medicare rates for comparable services. Medicare rates, of course, are frequently lower than those generally charged by practitioners in the communities in which they practice.

Unless payment rates for services to low-income patients are reasonably related to the costs that practitioners incur, many practitioners simply cannot afford to cover their liability and other practice expenses. It seems to us that, if policymakers are serious about steps to improve access, real efforts must be made to attract wider participation by the providers who can deliver the care needed. Among the steps required is an improvement in payments for primary care services, including the services of physicians and nurse-midwives. Some of the practitioner payment reform steps now being discussed by Congress for the Medicare program—if likewise applied to state Medicaid programs—could be very helpful in this area.

We appreciate your interest in our views about options for improving access to quality health care for every American.

Chairman Miller. Thank you.

Dr. Poland.

STATEMENT OF MARILYN L. POLAND, PH.D, R.N., ASSOCIATE PROFESSOR, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, WAYNE STATE UNIVERSITY MEDICAL SCHOOL, DETROIT, MI

Ms. Poland. I would like to thank you for the chance to testify before this Committee. I'm a nurse and an anthropologist in the OB/GYN Department at Wayne State University.

For the past six years I've been conducting research related to the high infant mortality and low birth weight rates in Detroit, a city with a chronic problem in this area.

My research addresses both access to prenatal care and birth outcomes. It includes interviews of over 1,000 poor women, evaluation of ongoing health and human service programs for pregnant women, and the development of a paraprofessional outreach program providing support to pregnant women and new mothers.

The research focuses on the most disadvantaged women, who are often under-represented in national and statewide surveys. The interviews we conduct use practical questions.

And the information can and has been used to develop new programs for these women, to evaluate existing ones, and to formulate state policies which are cost-effective.

Thus, the interviews are designed to give poor women a voice in programs and policies directed at improving their health and the health of their babies.

It is one piece of Michigan care model designed to forge partnerships between public and private agencies and the consumer to address serious health problems.

The information we have gleaned about what it is like to be poor and pregnant and to seek health care in Detroit is too vast to summarize here, so I will limit my remarks this morning to three areas.

The first is the value of prenatal care to women who receive little or no care. The second is the general fear and distrust of medical professionals. And the third is the use of substandard care in Detroit and its effects on the baby.

One of the major reasons poor women seek less than adequate amounts of care is that they do not believe it is important. They may not value it because of confusion about the importance of medical procedures used to monitor changes of their pregnancy. Many women do not understand why routine procedures are done.

In addition, there is disagreement between the women and medical personnel about what places a woman at increased risk of having problems during pregnancy. Women who do not view themselves as being at risk for health problems are less likely to place the same value on medical procedures and prenatal care.

While many clinics and physicians provide written information on medical risk factors, at least 14 percent of the women in our surveys cannot read above the sixth grade level, and many do not understand the written information.

Health care may also seem relatively less important because of the many ongoing problems and crises in the women's lives, such as finding adequate housing, obtaining food, clothing, and other basic necessities of life.

And, finally, women do not value prenatal care because we often fail to communicate its importance by the manner in which it is made available to the poor.

The average wait for a new appointment in Detroit is three and a half weeks, with some women reporting waits as long as eight weeks. Something which is important generally has a sense of urgency about it.

It is not unusual for a woman who registers late for care to receive her first appointment after she has already delivered. In addition, waiting times in the clinics are long, averaging over 3 hours to spend an average of only 12 minutes with the doctor.

The fact that women often see a different doctor at each visit prevents the development of a trusting relationship and discourages them from asking questions.

Women may also delay or avoid care because they are afraid of doctors and medical procedures. Much of this fear is due to a lack of communication between a physician and a patient.

And, finally, in Detroit, walk-in centers and, to a lesser extent, emergency rooms, have replaced the vanishing neighborhood physician as a source of prenatal care. In our surveys, 39 percent of the women received some to all of their care at these places.

When we read the women a list of routine recommended procedures for prenatal care, such as taking a blood pressure, measuring the growth of the fetus, taking blood, and other tests, visits to walk-in centers and emergency rooms did not include all of these basic procedures.

Women often told us that they were aware that the care was not as good as that given at clinics or in a doctor's office, but that convenience overcame these deficits.

Some of the highest risk women were using these sources of care. This use of substandard care has been shown in our studies to be linked with lower birth weights.

In summary, one of the reasons women receive inadequate amounts of prenatal care and substandard care in a large city such as Detroit is because there are weaknesses in our system of health care for the poor.

We are beginning to feed back information from the interviews to those responsible for programs and policies in Michigan. We feel strongly that if programs can be tailored to the needs of the people they serve, they will be more effective in encouraging women to seek prenatal care and in reducing our high infant mortality rate.

Thank you.

[Prepared statement of Marilyn L. Poland follows:]

PREPARED STATEMENT OF MARILYN L. POLAND PH.D., R.N., ASSOCIATE PROFESSOR, DEPT. OBSTETRICS/GYNECOLOGY, WAYNE STATE UNIVERSITY MEDICAL SCHOOL, DETROIT, MI

I would like to thank you for the opportunity to testify before this committee.

I am a nurse and an anthropologist on the Obstetrics faculty at Wayne State University in Detroit, and work in a hospital that delivers 46% of all the babies born in Detroit. For the past six years, I have conducted several surveys of over 1,000 high risk, pregnant women and new mothers to find out what it is like to be poor, pregnant, and to seek prenatal care in Detroit, and I have evaluated outreach efforts which encourage early and continuous use of prenatal care. These studies have focused on women at greatest risk of having a low birth weight infant in a city which has had an infant mortality rate twice the national average for the past 20 years. Access to prenatal care was a major focus because of the relationship between receiving inadequate amounts of prenatal care and the birth of small babies who are at greatest risk of dying. Our research indicates that a complex set of interrelated factors affect the amount and quality of prenatal care a woman receives. I will limit my remarks to three barriers to care which reflect failures within our health care system: 1) the women's value of prenatal care, 2) their fear of doctors and medical procedures, and 3) use of substandard medical care by pregnant women who may be at the greatest risk of complications.

One of the major reasons poor women receive little or no prenatal care is that they do not believe it is important. This attitude derives from several sources. First, some women who have had several babies believe that it is important to see a doctor often during a first pregnancy, but after that, a woman knows how to take care of herself. As one woman explained to us, ...as long as a woman feels healthy, the baby moves, she takes her vitamins and delivers at a good hospital, early and continuous prenatal care is not necessary. A second reason for not valuing prenatal care is confusion about the importance of medical procedures used to monitor changes over pregnancy and to prevent complications. For example, many of the women we interviewed did not know why they were asked to provide a urine specimen at each visit. Several guessed that these represented repeat pregnancy tests instead of methods to detect early kidney problems or diabetes. More importantly, there was disagreement between women and medical personnel on what placed a woman at increased risk of having problems during pregnancy. When we asked doctors and nurses what constituted high risk, they agreed that having high blood pressure, delivering a previous baby who was low birth weight, and having more than five babies placed a woman at added risk of future complications. When we asked the women what constituted high risk, they agreed that hypertension was a serious problem, but felt that not taking vitamins placed them at jeopardy. Having a previous low birth weight infant was not seen as a risk factor because each pregnancy was viewed as an independent event, and having more than five babies actually reduced risk because they felt a woman's body was stretched and that made subsequent pregnancies and birth easier and less risky. Women who do not view themselves as being at risk for health problems are less likely to value medical procedures and prenatal care. While many clinics and doctors' offices provide written information about pregnancy risks, this information is generally written at the eighth grade level or above. In our surveys, at least 14% of the women could not read above the sixth grade level. A third reason that prenatal care is less valued is its relative importance given the many crises in the women's lives. To be very poor may mean living in substandard housing; having no transportation; being in constant fear from drug related violence; not having resources to pay for food, clothing, furniture and utilities; and having a sense of despair and hopelessness. Although 85% of the pregnancies in our sample are unplanned, most of the women wanted to do whatever they could to have a healthy baby. But when they are faced with a choice between waiting for a welfare check to buy basic necessities before the money is stolen, or to keep a prenatal appointment, -- prenatal care becomes less important. And finally, women do not value prenatal care because we fail to communicate its importance by the manner in which care is made available to the poor. Something which is important has a sense of urgency about it. In Detroit, it takes on average of more than two weeks to get an appointment at a health department clinic, and 3-1/2 weeks at the high risk clinic located at our hospital. Some women reported waits as long as eight weeks. It is not unusual for women who registered for care late in pregnancy to receive an initial appointment past their due date. Additionally, once the appointment date arrives, women have long waits at the clinic. We conducted a time motion study at one clinic and found, on average, women waited 3.3 hours to spend an average of 12 minutes with the doctor. This does not leave time to develop a trusting relationship or to ask questions. The fact that women often see a different doctor at each visit further erodes communication and the value of the visit to the woman. Our public clinics have increased the number of patients they see over recent years due to private physicians leaving the city or refusing to see women on Medicaid. This has limited the options for and availability of prenatal care and has produced overcrowded clinics. Prenatal care could not be very important if the system responds so slowly to a request for an appointment and spends so little meaningful time with its patients.

The second reason women delay prenatal care is fear of doctors and procedures. One concern some women expressed is that doctors order tests or perform procedures without their consent or understanding. Much of this fear is due to a lack of communication between physician and patient. Patients said doctors used words they did not understand or did not give them time to ask questions. Some women were afraid to ask questions because they did not want to appear ignorant or to question the doctor.

The third factor relates to the quality of prenatal care that poor women received. In Detroit, as in many other cities, emergency rooms and walk-in centers often serve as the main source of medical care for low income women who do not have a regular source for health care. In Detroit, walk-in centers and to a lesser extent, emergency rooms, have replaced the vanishing neighborhood physician as a source for prenatal care. In our surveys, 39% of the women received some to all of their prenatal care at these places. When we read the women a list of routine, recommended procedures for prenatal care, such as blood pressure recordings, urine tests, blood tests, measuring the growth of the uterus by measuring the abdomen, and others, most visits to emergency rooms or walk-in centers did not include all of these basic procedures. The women often told us that they were aware that the care was not as good as that given at prenatal clinics, or at a private physician's office, but that convenience overcame these deficits. Walk-in centers do not require an appointment (25% of women did not have a phone), the women can bring their children and thus do not need a baby-sitter, the centers take Medicaid, the women are "checked by a doctor," waiting time is often less than 15 minutes, the doctors did not recommend frightening procedures and doctors often kept regular hours so women could arrange to see the same doctor. Thus, most of the problems that women encountered in a busy prenatal clinic were avoided. Some women we interviewed used walk-in centers and prenatal clinics. One high risk mother of six, with hypertension, kept her appointments at a high risk prenatal clinic when she felt well, but visited the walk-in center when she did not feel well enough to take the bus and wait for long periods to see the obstetrician. Preliminary analysis of our current survey of over 600 women reveals that some of the highest risk women are receiving substandard prenatal care. Although many have told us that physicians in the walk-in centers have referred them to regular and high risk clinics, some prefer to remain in the walk-in centers because of the convenience. This use of substandard care in Detroit cannot be dismissed because our research indicates that the amount of prenatal care a woman receives and the source of that care are both associated with birthweight.

In summary, I have outlined three reasons why some low income, pregnant women in Detroit fail to receive adequate amounts of quality prenatal care. Many program and policy experts around the country have asked why some of our highest risk women do not come in for high quality prenatal care, even when it is available in their communities. When one stops to consider the many problems they face, including lack of basic necessities of life, - long waits in a busy clinic - to spend a few minutes with a doctor they have never seen before - who uses technical terms they do not understand, - and who has to hurry to see the next patient; perhaps the question should not be "why don't they, but "why do they?" I also feel that it is vital that the kind of information in our survey is collected in other areas of the country with high infant mortality rates. Birth statistics are not enough. Effective programs and policies that support efforts on behalf of mothers and infants must be based on the values, lifestyles, and experiences of the people they hope to reach or they will not work.

Chairman **Miller**. Thank you very much.

I don't quite know where to begin with you, but let me start here. With all due respect to my colleague Mr. Bliley and his discussion of their study this morning on why people didn't use these services, the notion about a lack of coordination emerged when he talked to the providers of the service. I get a somewhat substantially different picture, when both of your surveys involved talking to women about why they didn't come. We get right back to financial barriers. We get back to something as human as fear or misunderstanding or non-understanding about the importance of care, or, transportation, which are fundamental and daily problems in life in terms of barriers.

Would you care to comment on that? I'm trying to do this delicately, but I'm sure that the lack of coordination in services provides for gaps in services, but I don't know that people think, "I'm not going to go there because it's not a coordinated program." They probably say, "I'm not going to go there because I can't afford it" or "They're mean to me" or, you know, "I don't have a bus token."

I mean, I'm trying to throw this out for discussion here. You don't have to pick sides. Just tell me what your study said.

Ms. **Poland**. One of our conclusions, from talking with many women and also from working with our advocates who follow these women through the first year of the baby's life, is that if you live in inadequate housing in a poor area of Detroit, you must take three buses to come into a busy coordinated clinic, and it takes you an hour and a half to get there often in bad weather. . . .

Chairman **Miller**. You're not paid for that right?

Ms. **Poland**. No, you're not paid for that, and it's a dollar each way plus 10 cents for each token every time you transfer.

In addition you have to find a baby sitter, and those are expensive.

You have to wait three hours to see the doctor for 12 minutes.

You're not feeling badly anyway. The baby moves. You take your vitamin pills. You register at a good clinic.

You've got to run to see your social worker because your monthly medicaid form has just come in and if you don't renew that form, you'll lose your Medicaid insurance.

You're worried because your welfare check is coming in. If you're not home to receive it, somebody else will steal it and cash it for you.

If you're involved in all of these domestic problems where you worry about paying the rent and paying utilities, finding food, clothing, and shelter, then prenatal care is relatively of little importance.

Chairman **Miller**. Okay. Wait a minute. Stop right there. That's a view from the——

Ms. **Poland**. The woman's perspective.

Chairman **Miller** [continuing]. Woman's perspective, the patient's perspective.

Ms. **Poland**. Yes.

Chairman **Miller**. Then, Dr. Davidson, you're talking about a doctor who says, "There's screwed-up paperwork. They're not going to pay me. They're going to challenge my decisions. They're going to pay me partially what my time is actually worth. And I'm not going to participate."

No wonder women are not getting prenatal care. I mean, we've got a head-on wreck here between the two participants. Is that fair?

Dr. **Davidson**. I don't think the participants themselves, the doctors and the patients, are headed toward each other as a wreck. They are headed toward the system for the wreck. And we both, the patient and the physician, are both in this same vehicle headed toward this wreck, and it's serious.

I think the fundamental problem is that we would have to make a national commitment, not necessarily a dollar commitment, but a resolve that any woman in this country required, deserved, and we were better off if there was an investment in adequate health services for her and her family.

And if that resolve were undertaken, many of the other administrative and financial problems I think that we have, then people along the line would be forced to deal and remove them.

Chairman **Miller**. But you can't arrive at that decision as long as—I mean, I'm making a statement here, not putting words in your mouth. It seems to me you can't arrive at that decision as long as you continue to have essentially a segregated system, by age or by income or by geography or what have you. And that's what it seems to me we have in this country.

We just went through the catastrophic health care battle where we're trying to provide add-ons to an underlying system that is already so expensive that any add-on becomes prohibitively expensive, especially if those people have to pay for it.

So, I mean, you're talking about national health care. You're talking about if you're sick, you're entitled to services or if you're pregnant, you're entitled to services.

Dr. **Davidson**. And we do that for a large part of the population except that that group that is presently under or uninsured. And in a large part of this society, we do consider that health care is necessary and it should be available, and we've made arrangements for doing that.

And I just think we just have to go the final step and especially focusing on the parts of the population that are the most vulnerable in terms of pregnant women and children and the ones who are going to provide the most in long-term contributions to this society.

I would like to make one other point. As important and as cost-effective as prenatal services are, it seems that it has become unpopular to include the very vital provision of preventive services for getting pregnant in the first place in unplanned and in unoptimal circumstances.

There is a direct link to infant mortality and morbidity associated with women who are pregnant under unplanned circumstances and in which caring for that pregnancy is not a high personal priority.

And it is clear that those pregnancies are going to have outcomes that are markedly different than someone who is in a social circumstance in which they want to be pregnant and they are trying, working on behaviors to protect that developing fetus.

Family planning and other services in this country deserve and require much more attention in this equation.

Chairman **Miller**. I agree with everything you have said, but we are not talking about one of the great mysteries of the universe here. In fact, I assume Dr. Poland and Dr. Thompson and you, Dr. Davidson, have all seen successful models out there where, you don't have to go through this rigamarol. There are programs for women who are pregnant that are able to inform, educate, and change behavioral patterns and make women's self-esteem rise so that they have a different view of the fetus and the resulting child.

We've demonstrated that time and again. We've demonstrated time and again that we can make these systems accessible, that we can help people through the system, and we can have successful outcomes.

We keep giving grants to demonstrate this over and over and over again. But somehow it doesn't then get translated to national policy. Dr. Mason, the Acting Surgeon General, essentially said knowing all that we already know, we can reduce infant death by 25 percent.

And I'm staying away from, for a minute, the overlap of AIDS and crack for a second. I want to get into that.

But do you agree with him? I mean, that's a fact. He made a correct statement. We know what to do. We're just now dealing with implementation, whether or not we're going to streamline the barriers from the providers' side and whether or not we're going to reduce the barriers from the patients' side.

This isn't original science we're talking about, is it?

Dr. **Davidson**. That part isn't. And, clearly, you could almost immediately reduce, certainly, in one to two years with aggressive programming that 25 percent that would respond to these kinds of programs that we know how to deliver.

But it would be unfair and incomplete not to recognize that in that other 75 percent, we need some more information and some more science. And the big problem——

Chairman **Miller**. No argument. No argument there.

Dr. **Davidson**. So I just don't as a matter of balance——

Chairman **Miller**. I don't want that discussion to limit our horizon to a population that we already know this is possible with.

No question. We spend a great deal of time in this Committee on the rest of this population that presents some difficulties. I don't know institutionally whether we have the ability to deal with them or not.

Ms. **Thompson**. I'd like to comment on that. I think that we've, as you have said, spent a lot of money in demonstration programs and found out that, indeed, they do work.

And we do understand some of the things that need to be done to keep babies from dying and women from dying from a condition that was never intended to kill them.

And I think part of the difficulty may be, in addition to lack of political will to do some of these things that we know how to do, has been precisely the demonstration projects.

They were never picked up in the mainstream of health service delivery. And so they were lost.

Chairman **Miller**. We're going to let grants, I assume, this year again.

Ms. **Thompson**. Right.

Chairman **Miller**. Because someone is going to come in and say that this is novel. It's no longer novel.

Ms. **Thompson**. So part of what I'm suggesting is a revision in the entire structuring of prenatal care services, but also the financing of the services so that what we know how to do, especially in the area of health promotion and psychosocial risk reduction, smoking and drug abuse and those kinds of things, gets integrated into the programs and get reimbursed so that it is a coordinated program, rather than having to do it in repeated small demonstration issues around the country.

Chairman **Miller**. Well, I think—and, again, without putting words in your mouth, I think Congressman Machtley made the point. This Committee has listened to testimony on fetal alcohol syndrome, where scientists and doctors and others have told us that even severely addicted women in some instances, not in all instances, in some instances, can be encouraged and, in fact, give up alcohol during the term of pregnancy because of their sense of well-being about the baby.

And so it's been demonstrated. It doesn't say we're going to have a 100 percent guarantee, but it's been demonstrated time and again that a little bit of education works. We used to think you could have two glasses of wine a night and you'd be fine. Now, education has moved us and said no wine, no nights, ever.

That can be done. And it's been done in local communities all over. But it's not a matter of integrated policy within this delivery system. That's what you're telling us.

Ms. **Thompson**. It also is not a matter totally across the system of an integrated education of providers to add the skills that are needed to motivate women or to help to support them as they take on the motivation to be healthier.

And I think that we need some attention to the preparation of our providers so that we can expand, either coordinate the services of health educators and social service people who work with the prenatal care providers, but at least at the very minimum to have a commitment to a broad scope of services for prenatal care.

Chairman **Miller**. Let me raise another point, Dr. Davidson, because you've raised it several times, and, obviously, the study raises it. And it's worthy of much more extensive discussion.

But my father warned me never to practice law and I've taken that direction. I am a lawyer. And if I were to pick one side or the other, I would pick the plaintiff's side. And I would be suing doctors, I guess, probably at some point down the line.

Congressman Durbin has been very interested in this, and we have had some hearings on the extent to which this legal system is starting to preclude access to care, certainly with respect to Medicaid and Medi-Cal patients in our states.

And when you talked about a drop-in delivery, where the woman simply shows up with no history of contact with the medical system, that doesn't give her the right to get a bad doctor or to have a careless procedure. It doesn't give the system the right to visit you with a bad doctor, bad procedures, or less than adequate care.

By the same token, I'm not sure that all of the problems of that woman and that delivery should be visited upon that particular physician or that medical institution if that delivery is made, because they, essentially, have little or no control over that. And I suspect that is why a number of these institutions are turning these people away.

The theory would be that if we put a cap on liability or we prescribed the rules, the more stringent rules, the basis on which you could sue or what have you, that that would lower the premiums that doctors would pay and that would make it more attractive.

In the study, was there a discussion of those trade-offs? I mean, very often we do things that we think are going to lower insurance premiums, and nothing happens.

And we see crises that, in fact, had nothing—we went through a day care insurance crisis that had nothing to do with the child care industry, had nothing to do with the risk, had nothing to do with anything other than the economics of the industry.

But, you know, I would be willing to consider, as one who is greatly enamored by the plaintiffs' bar, that if there were, in fact, a trade-off, that would bring physicians into the delivery and into the providing of care.

Was there a discussion of how you would structure that system?

Dr. **Davidson**. I wasn't a part of the medical liability panel, but I am familiar with the report and its recommendations. I think that that panel and others who have looked at the medical liability problem have reached the conclusion in general—and I know this is difficult in a legal system constructed such as ours—that the tort system itself is probably a very poor and inadequate approach to dealing with disability that either occurs spontaneous or as a result of medical intervention, is that that adversarial contentious system ultimately across the board does not serve the patients who need the benefit.

And in the current system, the patients who are disabled are only getting a fraction of the dollars that are spent in the medical liability enterprise.

It is very easy to see that around the medical liability issue, we have almost developed a subsidiary parallel enterprise and, particularly, in obstetrics, having not to do with good or bad doctors or good or bad medical care. And that's not to ignore that there are some elements of that in this equation.

But it has to do with an independent set of forces that tend to drive that system that is unrelated to quickly defining what is wrong with the patient and quickly organizing resources that would directly benefit that patient.

So most of the thinking has been that ultimately some alternative to the present tort system should be implemented to address the medical liability problem. And I subscribe to that view, despite the fact that some tort reform, as you have indicated, capping premiums and awards, et cetera, might be helpful.

I don't think the ultimate solution for medical disability and events is going to be best served by the present tort system.

Chairman **Miller**. Okay. Thank you.

Congressman Machtley.

Mr. **Machtley**. Thank you. There are approximately four million births a year, as I understand, and I'll just go through a little narrative. And then whoever would like to answer the question can perhaps try.

I don't have a complete grasp of how much money we're spending to try and deliver four million births a year. In the last testimony, we heard that if we spent $500 million more, we might, in fact, be able to intervene and save two billion.

If I could use the simple analogy without the correct numbers, the question I have is: If we had $100 to spend, it is certainly possible that we could spend $90 on people who were just never going to come in, no matter what we did and, unfortunately, spend $10 on some of those who would benefit by counseling and who would gladly come in, the people who if we said "We'll provide you the services. We'll help you to get there" would show up.

How are we doing on identifying which people we can help and where we should channel our resources, as opposed to just saying, "Well, let's throw $500 million more at a problem" and not know will we, in fact, impact the birth mortality rate?

Dr. **Davidson**. I think that is a very good question. And the Institute of Medicine panel—and I hope that Ms. Brown also takes an opportunity to respond—was charged to look at outreach. In other words, what could we do just to reach the women who were not coming into care?

And what the panel found was: You cannot address outreach in a system that is so disjointed and inadequate that you don't even know what the normal participation is. You've got to have a system that is available that is providing enough care to really know how many women would still stay outside of that network.

So part of the information that you're asking except in select circumstances in which, you know, reasonably comprehensive and accessible care has been provided, we really don't know.

Our feeling is that if you had a system that provided adequate care and a culture that said that the care was necessary, then we would probably end up with a small group of women in which intensive targeted care and outreach would be necessary.

Ms. **Poland**. I'd like to reinforce that. You have asked a very important question. Our outreach program, was a demonstration project, and an experiment. We wanted to see if having an advocate would help a woman keep prenatal appointments and have a healthier baby. We also took a look at the clients themselves and assigned half of the clients who entered prenatal care very late in their pregnancies to receive advocate services.

We divided, the other half—the 25 percent who came in early and 25 percent who came in about the middle of their pregnancies, to advocates.

We found that having an advocate increased participation in prenatal care in all of the groups identically. They all made a significant difference. What we missed were the women who never entered the prenatal care system at all.

What we have done this year is to change the focus of our outreach program. Now, the client is not just the individual woman, but it is a community, a series of neighborhoods.

What we're looking at now is: What is the responsibility of a community to identify and to help women receive prenatal care? And so our advocates are working with community groups.

They will be in grocery stores, and the checkout counters. They will be taking a look at different ways of energizing a whole community to participate in promoting the importance of prenatal care and also in infant care.

Ms. **Brown**. Could I just add another word on the outreach topic? The situation is something like this: About a third of the pregnant women in the U.S. don't get the amount of prenatal care that's currently recommended by the obstetrical professional groups. Too often, communities attempt to improve matters by saying, "Well, let's send outreach workers out after them."

But what we have found is that although outreach workers help people over and around barriers to needed care, they are not able to remove the barriers to start with.

So we have outreach workers who help women get Medicaid and get WIC, but those programs remain chaotic. It is thus not very helpful in the long run to fund outreach if we're not going to repair the underlying systems that outreach workers help women negotiate.

Mr. **Machtley**. Okay. So now we get down to these 10,000 babies we could save. How do we identify these pregnant mothers? If we know a statistic, are we doing anything at the hospital, at the delivery end, to identify who are these mothers and how could we have intervened earlier?

I mean, we're only talking nationwide 40,000 deaths a year, which is a tragic figure, but I'm saying it's a manageable number to do a study, as opposed to 4 million births.

Do you know if we're doing anything in that regard?

Dr. **Davidson**. Well, the biggest single indicator in the simplest form of what is a risk for pregnancy is no or inadequate prenatal care. That's the biggest single risk factor.

And we know, from the day-to-day experience in this country that there are thousands of women who are not getting prenatal care. And they are having a remarkably different and poorer pregnancy outcome.

So it looks like if you were going to do one thing that had the most broad-based benefit, it is just ensure that they got into a simple, low-cost, low-tech prenatal care, which most of them probably would need.

And then those who had identifiable risks could be picked out for other services.

Ms. **Thompson**. I think we also need to address the issue of providers being available to do that. And part of what Dr. Davidson addressed to the liability issue hit home with the nurse-midwives three years ago when we were in a position where we couldn't even purchase liability insurance, and several of the providers had to go out of business at that point in time.

That has now been remedied. We are able to purchase that coverage. But I think part of the solution in getting providers out is to rely more and more on non-physician providers of prenatal care, going back to public health nurses, a reeducation and reuse of what Dr. Mason was talking about, an earlier public health system that actually did work, and to help bring back the good elements of that system with nurses, nurse practitioners, nurse midwives, in addition to the increased use of family physicians and obstetricians, in this total team effort to get care to people who currently geographically don't even have access to care.

Mr. **Machtley**. I wanted to follow up, then, on the legal system. We have been quick to point out that there may not be a national health policy, and we quickly point out that it may be our fault, that, clearly, the Administration may not be leading the way.

I want to throw the spear right at us, Congress, on the failure to take action on medical malpractice. We sit here, and we can criticize. But I have three personal friends who have now stopped delivering babies because of their malpractice insurance costs.

There is now—I addressed a conference, and a major medical figure spoke—no obstetrician between lower Fort Lauderdale and Key West willing to deliver babies. And that's because of solely, in my opinion, malpractice insurance costs. And Congress refuses to address it.

I'm a lawyer. Many of us are lawyers. And we all recognize the system, but, clearly, it is devastating the number of physicians who are willing to go into health care.

And we ought to look at ourselves, as well as the Administration, and say: Why aren't we standing up doing something about this major problem, even if we just deal with obstetricians and forget the rest of the system for the moment?

So I, for one, will stand up and say we are afraid or not doing what I think we should do here in Congress in malpractice tort reform because it's having a direct impact in my area and every area of the country.

But I also think that we need to look at how we distribute our monies. And maybe the first place to start is, if I'm hearing you correctly, to gather the data to find out how do we encourage some of these mothers who would otherwise want to come into the system, but don't.

How do we identify who they are without having to just shotgun the money out there? And I suspect that's where we are now, increasing the costs. We at the end of the year say we didn't reach our target. Why not? Because we didn't know in the first instance who these mothers were.

Thank you.

Chairman **Miller**. Thank you.

On the issue of medical malpractice, there seems to be some conflicting evidence here. And, again, Dr. Davidson, you weren't part of that panel, but one is the number of studies that suggest to us right off the bat that the poor are far less likely to sue and far less likely to get a major judgment.

And, yet, somehow it's the poor that are being denied access because of the problems of getting medical malpractice for obstetricians and others. Well, that doesn't square with the studies if that's the reason.

If the studies are accurate, you would only take poor women in and deliver the babies. You would leave the other ones out because they're the ones that are going to sue you and get the fancy lawyer.

Dr. **Davidson**. I think you have to tease out some apparent paradoxes, as you have identified. And it may be that the medical liability experience in obstetrics is different than general medical liability experience.

And that is to say that there is a special—well, first of all, the facts are that there are higher awards and settlements having to do with disabled children.

And there are probably lots of contributing factors into that having nothing to do with medical malpractice, per se. And I really feel strongly about that.

It's almost as if—this is a private non-scientific observation. It's almost as if——

Chairman **Miller**. As opposed to ours, which are public and very scientific.

Dr. **Davidson**. That's right. It's almost as if it has become a means of insuring disabled children in which there is no other direct way of providing economic and medial support. And that just happens to be a social opportunity.

And I think that that's a misuse of the tort system in that regard and that we could provide help for those individuals much more directly and much less expensively and with much less of a hazard to the physician-patient relationship than is currently being conducted in this system.

So, on the one hand, I think there might be legal people who might be attracted to a disabled infant as a malpractice case, although the woman is poor, despite what might be the experience in non-obstetric circumstances. I think this may represent a special problem.

Chairman **Miller**. Thank you.

Congressman Durbin.

Mr. **Durbin**. Thank you.

I'm sorry I had to step out in the middle of the testimony, but I had some constituents here to visit with.

Before I was elected to Congress seven or eight years ago, my law practice consisted not exclusively, but primarily, of medical malpractice. And I spent many years defending doctors and many years prosecuting them. So I have seen many of these cases from that perspective.

I don't know that that makes me particularly well-qualified to analyze the problem. And I haven't introduced, if you'll notice, in seven years the Dick Durbin solution to the medical malpractice problem in America because I don't believe it's an easy one to deal with.

I do think that some of the proposals or recommendations that have started to come out—the reprint from "The New England Journal of Medicine," which was given to me by the staff at ACOG, I think, has some good, valid starting points.

But I would suggest to you that, strictly from a political viewpoint, one of the first questions that has to be addressed and put to rest is the role of the insurance companies in the premiums that they are charging—to make certain that they are justifiable.

And I don't know if that has been already discussed during the course of this panel. But once that is resolved, in whatever direction it is resolved, then I think we're at a point where we can then address the crisis as it exists.

But until then there is a suspicion engendered certainly by the lawyers that the insurance companies are making all the money in this and that the calls for tort reform are basically to mask some unconscionable profits being made by insurance companies.

I think, unless we can come up with some neutral group that takes a look at it and analyzes the insurance companies, we'll continue to run into that brick wall as we address this problem.

Of course, I would leave it open to any comments you might have. I'd like to just address one aspect of this whole issue which I've looked into quite a bit in my home State of Illinois.

I don't know what the word "psychosocial" means. I mean, I've heard it said. I think I can figure out what you're driving at here. And maybe that's what I'm about to discuss.

But, for whatever it's worth, it seems to me that there have been some dramatic changes in attitudes that have had an impact on infant mortality. Let me give you two examples.

An obstetrician comes to see me in my hometown of Springfield, Illinois and says he's about to hang up his shoes. He's not going to do this anymore. The medical malpractice premiums are too much. The reimbursement rate from the state, for example, for Medicaid recipients is too low. It just isn't worth the battle any longer. He's going to make exclusive the specialty of gynecology.

And then, almost as an aside, he said, "It was curious. When I first came to this city 25 years ago, I used to take these poor women in and treat them for nothing. I accepted it as my professional responsibility. Everybody did." This was before Medicaid reimbursement.

"And now," he says, "I have my fellow professionals who will not treat them at all unless the level of reimbursement is high enough to compensate them for malpractice and overhead and the like."

He said, "Boy, what a change there's been in the last 25 years." I wonder if that's just a change that can be blamed on government or whether, in fact, it's a change in the attitude of the profession toward their professional responsibility toward poor people? The first question.

The second question is this: The people I speak to who deal with the women who are having repeat pregnancies, teenage pregnancies, low birth weight, complications, and the like are some of the most discouraged people I've ever run into in my life.

They come up with some of the harshest suggestions on how to deal with this thing, from sterilizing people to—I mean, I can't believe that these words are coming from the mouths of the folks who have made their life's calling social work. But they are the ones who are the most despondent.

And they've become so despondent, I think, just by the volume of what they had to deal with, but also by the fact that they are sensing a loss of some basic maternal instincts in people, that women are having children with little or no regard for their own health, the child's health, or who is going to bring that child up.

And they are just fighting this every day, trying to convince the mother to, "Please not dilute the formula we give you. Give it to them the way we give it to you," "Don't reuse disposable diapers by hanging them over the shower curtain rod and letting them dry," things that just sound bizarre, but real-life problems.

I've given you a big psychosocial challenge here, I guess, but tell me: Are these attitude changes? Do you see them? Does anybody out here think I've got anything that's on the mark here?

Ms. **Thompson**. I think you've defined in a very nice way many of the psychosocial things we are talking about.

Mr. **Durbin**. So that's what it means. Okay.

Ms. **Thompson**. Part of the psychosocial is the economic status in which people live. And sometimes it's so poor that the resources to give to health are obviously not a priority when one is worrying about where one is going to sleep or even if one has to sleep on the street, as more and more pregnant women are doing these days and being counted among the homeless.

The psychological parts of that are the attitudes in some ways that you are talking about, the attitudes towards what does it mean to be a responsible parent, what does it mean to make a choice for parenting rather than to have a pregnancy as a side effect, if you will, of sexual activity and not as a planned activity to parent.

And I think the discouragement is certainly there among my obstetrical colleagues, among my nurse-midwifery colleagues who have, as you probably know, long traditions of working with socially at risk, disadvantaged, high risk pregnant women and actually having success to some measure in improving the health outcomes for both the women and their infants.

I think the growing fragmentation attitude of the system that we are working in—not the attitudes of the providers, has changed, which is why you see the discouragement.

I think if they really wanted to give up on the whole system, they would have just become apathetic, as some of our systems have become. So I think the provider attitudes are still there. We're still committed to caring for both the medically and the socially disadvantaged women during pregnancy.

There's renewed interest in doing that. It's becoming more and more difficult to do that. And the issue of should we go back to providing free care? If, in my nurse-midwifery practice, all I cared for were those who couldn't pay, I would not be in practice.

And I think that there is some balance, some need to have some financial resources, along with the provider resources, to deal with the issues.

I think the societal issue of whether or not responsible parenting will ever be discussed openly is another issue. I think I would support what Dr. Davidson has said in relation to family planning and increased emphasis on helping women and men, and not leaving the men out any longer, to plan for pregnancies and not simply to have them as a byproduct of our sexual activity.

Mr. **Durbin**. If you could figure out how to get the men into this equation, please let me know because it's really sad that——

Ms. **Thompson**. We start in fourth and fifth grade.

Mr. **Durbin**. I think you're right. I really think you're right in terms of——

Ms. **Thompson**. And part of the providers——

Chairman **Miller**. Apparently, pregnancy is still a mystery to the male part of the population or something. I don't know.

Mr. **Durbin**. Well, it is. It's a mystery in terms of our policy. We direct everything toward the women involved in this. And although organizations like The Urban League and the others have tried their very best to take the other side of this issue and present it, boy, they are having a tough time of it.

And I think you are correct in that you've got to start in the early education and the values involved.

Ms. **Thompson**. The expert panel toyed with the idea of making the recommendation that pre-conception care would start in first grade, but we recognized that that would not be a popular recommendation, nor possible at this point, but certainly to begin prior to the ability of young boys and young girls to conceive is a better place to begin with our next generation of responsible parents than after they've already conceived.

Mr. **Durbin**. But, really, pre-conception care has to begin at conception.

Chairman **Miller**. Go ahead, Dr. Davidson.

Dr. **Davidson**. I'm glad you're fair enough to us to recognize the complexity of your question and the difficulty about giving it a simple response.

I think what has happened in this country in terms of many of the workers on the front line around the pregnancy problem is we have, in fact, had a revolution in this country having to do with sexual practices for people of all ages. It's a much more open society in that regard.

And we have not made the kinds of adjustments in education and services that would minimize the bad aspects of those practices having to do with sexually transmitted disease, unwanted, unplanned pregnancy and et cetera.

Other societies in the western world have ultimately gone through phases that we apparently appear to be in and have ultimately been more effective in terms of educating and providing services, even to young people, to stop that series of bad events that lead from early sexuality and untimely pregnancy.

And we are just confused as a society about doing what is right and effective in that regard. And I think we are going to stay hung here until we reach another consensus about what can be done effectively in that regard.

And I think that many times health workers who see the need are often frustrated both by what they see recurrently happening to the people they serve and also recognize that if some more rational things were being done and supported in the broader society, that those events may not continue to happen.

In regards to the physician attitude—and I think it's fair to raise that kind of question about voluntary contributions to care; I also think that's equally complex—first of all, there are a lot of physicians providing care to poor and underserved women in this country today, for which they are not getting as much credit as they should.

I think part of the urbanization of this society and putting people into highly impersonalized circumstances, in which there is not a lot of immediate opportunity for person-to-person kinds of connections and contributions in terms of that level of volunteerism, probably has affected us broadly, not only just in medicine.

And you can realize that contrast when you look at smaller and more rural communities in which you still have that kind of participation.

So I don't think that it is fair to single out one professional group under this complex circumstance and blame them for an unhealthy and unfair attitude.

I think we've just really got a complex situation, and we're going to have to look at solutions that are equal to the complexity of the society that we are living in.

And I just don't think we're making some of those social adjustments fast enough. And we are probably doing too much talking about it and too little acting upon it.

Mr. **Durbin**. Thank you.

Thanks, Mr. Chairman.

Chairman **Miller**. Ms. Robinson, let me ask you a question. You've listened to some of this discussion. What's your reaction? Well, I guess I have two questions.

One, how do you find the people for your home visiting program? Are these people who have already come in or are these people you hear about by word of mouth who are pregnant?

And what's their reaction when you first visit them and first talk to them about your program?

Ms. **Robinson**. We find these clients—some come into the clinics for the first time and don't return back—referrals.

Chairman **Miller**. So someone might come in, and then they don't show up again? So you're sent out to find them and ask them why they're not coming into the program on a regular basis?

Ms. **Robinson**. Once they come into the clinics, they fill out a prenatal questionnaire. And sometimes they show back; sometimes they don't, or they move around to a different clinic.

And we track these people down, and some word of mouth, social service. We have the baby van, different organizations.

Chairman **Miller**. How do you establish a bond with them, a trust to get them to come in and take part in the services?

Ms. **Robinson**. Well, when I go out and make a home visit, usually I don't go in talking about prenatal care. Because if you go in and there's a person there with no food or about to be set out, they don't want to hear nothing about prenatal care.

So I start where they want to start at. "Well, what is it that I can do to help you?"

Chairman **Miller**. As was pointed out by Dr. Poland, you're talking about a population that has a whole other series of problems and things that may be more important at that moment in their life than the issue of prenatal care?

Ms. **Robinson**. Yes, I am.

Chairman **Miller**. What you're telling us is that you're using their other difficulties and solving some of those problems to lead them around to a point where they're confident in you? And then you can get them to start thinking about prenatal care?

Ms. **Robinson**. Yes.

Chairman **Miller**. You have a very challenging job. Thank God you're there.

But I guess what we find out is that many of these women don't live with each of these problems in isolation. They all sort of arrive at the same time or they're just part of a larger mix of difficulties with their daily lives.

Ms. **Robinson**. That's right.

Chairman **Miller**. User friendly, huh?

Thank you very much. Unless there are other questions by members, thank you very much for your testimony and for your help. I think you've stimulated us to ask some additional questions down the road here about this system. So we appreciate it.

The next panel will be made up of Dr. Wayne—excuse me. Dr. Niles, if you would join this next panel, I would appreciate it. He is from the Mayor's Advisory Board in Washington, DC; Dr. Wayne Burton, who is from Chicago, Illinois; Dr. Jennifer Howse, who is from White Plains, New York; Dr. Joan Eberly, who is from Benton Harbor, Michigan; Kathy Ruscitto, who is from Syracuse, New York, accompanied by Dr. James Miller from Syracuse, New York.

Welcome to the Committee. Dr. Niles, we'll start with you. We're going to have to get you a microphone over there at that end of the table. And, again, proceed in the manner in which you're most comfortable.

Your written statements will be made a part of the record in their entirety.

STATEMENT OF JOHN H. NILES, JR., M.D., PRESIDENT-ELECT, MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA; FORMER CHAIRMAN, MAYOR'S ADVISORY BOARD FOR MATERNAL AND CHILD HEALTH, WASHINGTON, DC

Dr. **Niles**. Thank you, Congressman. I'm sorry I'm late. I had to give a lecture on carcinoma of the cervix this morning, so it's been a busy day today.

In discussion with staff on this issue as to how I could participate and help with the discussions and concerns about what we can do for prenatal care and the issue of the non-financial barriers to care, I'm a practicing obstetrician/gynecologist. I've been practicing since 1971.

I've always been a Medicaid-participating physician until the 1st of September this year. And I made a determination that at this particular point in time, with my practice—I'm a solo practitioner—that I would have to limit the volume of patients I would be seeing in the Medicaid program.

This was a difficult decision to make, but I decided to continue to service the patients that I had already been servicing as far as the Medicaid population, but not accepting any new patients.

But with that experience, however, there are a number of things I have found that have, I guess, developed a level of stress or frustration with the system, so to speak, in terms of the non-economic barriers that cause problems in terms of even being able to provide care when I'm providing care.

I've sort of listed some of those things, and I'll go through them very quickly so I can have room for the other panelists as well as making suggestions for what solutions I see. Many of them you've already touched on in the previous panel.

What we found in the District of Columbia—I have to speak specifically for the District of Columbia because there are other programs, Medicaid programs, that operate differently.

In the District what we have found is a difficult problem with the Medicaid application process. The reason given for this difficulty with the application process is the federal government in that there are concerns about those individuals who are receiving Medicaid who should not be receiving Medicaid.

Historically, in the past, when an audit is done by the feds, as they describe it, and determine that there are people who have been certified who should not have been certified, a certain percentage of numbers—they take 100 and they find 5, and then they say, "Well, this number," and they take it back from the entire budget at the succeeding year. And it has caused a lot of concern in terms of eligibility.

So the application process for the recipient, who has already got a disorganized existence to begin with—I don't know if any of you have ever seen the application for Medicaid in the District of Columbia, but they also are getting public assistance, WIC, Food Stamps.

The other argument, the other side of the coin, is: Well, this big application is necessary because we need to give them other services, not just Medicaid for medical services. They need to have all these other things, too. And if we restrict the application process, then they won't get these other services.

But if you look at that, they need a proof of pregnancy. They need rent receipts. They need a financial statement with assets and liabilities. They need birth certificates. They need proof of residency. The documentation just goes on and on.

Many times this requires multiple visits because they are told by one case worker they need one thing, when they get down there they find out they need something else.

These are the stories the patients tell me. Now, I haven't gone through the process. I have seen the application, though, and it is tedious.

What we have suggested in the past on the Mayor's Advisory Board is that the Medicaid process for prenatal care be streamlined, that patients also be able to get what we call presumptive eligibility.

The District of Columbia has not determined that they could afford to do that. The State of Maryland has done that.

With presumptive eligibility, which the Congress has allowed the states to do, a pregnant patient can receive services, reimbursable services, for 45 days while her application process is being adjudicated.

If at that point in time it is determined she is not eligible, then, of course, she would no longer receive it. But during this time, particularly with pregnancy and prenatal care, you need to get in early to do the things that Dr. Davidson was indicating. Prenatal care has advantages.

Now, a lot of the things that occur we can't control because preconception counseling has not occurred, but these patients need to get in for care.

And with the presumptive eligibility, they can get in quicker and be certified and have care and be evaluated.

The next problem is failure to keep scheduled medical appointments. The biggest problem I find in my office with the Medicaid population is keeping their appointments.

Now, it's not that I don't believe they believe that we're providing care or that the care is necessary, but if they're feeling okay, if there's a problem with a sick child, if their ride didn't come, there are a number of different barriers that just prevent them from the visit.

So they'll miss that appointment. They don't call for another appointment. They just don't show up or they forget their appointment or there's something else going on.

So we have a recall system in our office. And probably the thing my staff—they call me a tyrant—feels most concerned about is I'm always on their case about being sure the patients come in for care, calling them back.

There's a double-edged sword there. Besides the fact that I want to give them care and they need to come in, there's a liability situation as well if they don't come in.

Because if there is a problem and something occurs and I've not intervened appropriately, then it adds additional stress on my job to try to take care of them if they have a problem.

If we don't get the chlamydia culture and they get chlamydia and they've ruptured a membrane at 18 weeks or 20 weeks, then it would cause an additional problem as far as my care is concerned.

So this is getting the patients in for visits. Transportation is a factor. Child care is a factor. How do they get the appropriate child care? Is there a vehicle that can occur so they can get in for care and that will not prevent them from coming in to care?

Health education. I think it is very important, again, that we try to do as much as we can. The Advisory Board worked with WRC TV here in Washington, which is the NBC affiliated, and developed what's called the Beautiful Babies project. I'm sure any of you who have lived here for a while have seen our commercials.

And they don't come on at 3:00 o'clock in the morning. They come on at the regular, important times during the news. And WRC needs a lot of credit for getting that out.

So we have been trying to bombard the population with letting them know that it's important for prenatal care, and that needs to continue.

Drug addiction, however. In the District we have really had some dramatic changes. We had dropped from about 27 deaths per 1,000 live births to about 18. This was in 1983.

Then for the next 3 years we're at 19, 20, and 21. And now we've gone to almost 30 in just one year. And it appears to be the crack epidemic, as far as we can see. We can't put anything else tangible on that.

But what the drug addiction has done, it produces further disorganization to an already chaotic situation, which I've already described. Cash that the patients may have is utilized to purchase drugs rather than food and basic necessities. They're not paying their rent, being thrown in the shelters.

There's a high rate of sexually transmitted diseases associated with this crack epidemic. Either women or their partners are having a lot of sex or they are using sex as a vehicle for obtaining drugs themselves.

And we determined medically that pre-term labor can be precipitated by sexually transmitted diseases, gardnerella infections. You can have beta strep infections. You can have chlamydial infections, which cause premature rupture to membranes. And some of the toxins even suggest that it may cause increased uterine activity.

So that particular situation with sexually transmitted disease has related to increased pre-term births.

Many of the births we're talking about, infant mortality—and I don't know if it was discussed earlier—in what we studied in the District of Columbia, over half of those births were less than two pounds, those who died. Fifty percent of the deaths were in infants under two pounds. So they were problems in the second trimester.

Now, some critics will say prenatal care doesn't have any value because most of the births or deaths occurred in this population that you couldn't do anything about anyway because even if they came in for the visits, this would have occurred.

That's really not the case because if you can identify, treat these patients, the urinary tract infections, different things, we know a certain percentage of these are precipitated by these particular problems. You're not going to remove all of those pre-term labors, but you'll have a definite impact.

Now, the use of cocaine itself is a triggering physiologic mechanism for causing a patient to go into labor. So that in itself has increased another risk factor which we didn't have before.

Heroin did not do that. So it was more of a sedative effect. The babies had to be given Narcan at the time of delivery to make them wake up, but it was not an issue of getting them being born too soon. They had low birth weight, but the lung maturity was at a point where they could survive.

Housing is a critical issue. I just say the number of patients that I see, they talk about the problems with housing. Besides living in shelters that I see,—and this is something that I would say in the last two years, I can give you three or four patients off the top of my head who are living in shelters now who had stable home environments, so to speak, prior to this time, people living together, groups of people, sisters and grandmothers and two or three generations living, squeezed up together.

In Psychology 101, you know, you get a lot of rats in a cage, what is going to happen? There's going to be problems. There's going to be discord.

Housing, in the District, particularly, when you drive around Washington, you see all the boarded-up homes. Our developers are putting up brand new projects in Southwest. Yet, the boards aren't coming off the houses. Now, I don't know what——

Chairman Miller. I'm going to ask you to summarize.

Dr. Niles. Yes.

Chairman Miller. I'm afraid we're going to get into a voting situation here.

Dr. **Niles**. Okay. The last issue is the reduced availability of Medicaid health care providers due to lower reimbursements of Medicaid, excessive paperwork, delays in payment, high risk medical problems, high cost of medical malpractice.

And the last issue is job opportunity. Someone raised the issue about males. How do males get involved? Males get involved when they're working and can provide a home environment and a relationship.

If they are not working or not employed, it makes a big difference in the situation. And I think that the employment issue is extremely critical here, but the black male population are 50 percent unemployed. They turn to drugs to make a living.

I see a lot of the patients who come in with these designer bags. Yet, they're on Medicaid. And I know they're not buying them themselves. And this is going back to the crack situation with having sex. The high incidence of cocaine use is related to this.

No choice, I guess. They would feel it's no choice. I don't feel it's no choice, but they feel it's no choice with the economic situation.

To stop, I have listed what I felt were some solutions in my report in terms of some of the things you already mentioned.

The outreach services, I think, are very key and very important. The developed situations. We had a Better Babies project, which the Ford Foundation funded in the District, which no longer has funding because the District government would not pick up the cost of the program. It has demonstrated a valuable asset, but has not occurred.

And tort reform is another key issue. Providers are not going to continue to provide care unless there is some tort reform.

Now, the issue was raised about how this tort reform helped. We have a tort reform bill that has been introduced by the Mayor to the City Council.

It has been pocketed in the Judiciary Committee, who was a trial attorney, and we don't see any real way of it coming out in the near future. It's unfortunate. We're asking for a cap on non-economic loss, not on economic loss, but on non-economic loss.

The question was raised that I heard in the discussion: Well, how does tort impact? The insurance issue. Now, we have a physician-owned insurance company in the District of Columbia because no other commercial company would come to Washington to sell insurance.

So any physician who wants to come into the District from Maryland or Virginia pays a surtax to come into the District because of the lack of tort reform and the large judgments.

So tort reform is critical to providers and not just providers for women, but providers, period.

Chairman **Miller**. Dr. Niles, I'm going to ask you to wrap it up here.

Dr. **Niles**. Yes.

Chairman **Miller**. I'm going to lose my members quickly.

Dr. **Niles**. I'm finished. Thank you.

[Prepared statement of John H. Niles, M.D., follows:]

PREPARED STATEMENT OF JOHN H. NILES, JR., M.D., AN OBSTETRICIAN/GYNECOLOGIST IN PRIVATE PRACTICE IN WASHINGTON, DC

THE PROBLEM: BARRIERS TO MATERNITY CARE

- Red Tape in Medicaid Application Process

  Multiple Requests for Documentation

  (1) Proof of pregnancy; (2) Rent receipts; (3) Financial Statement (assets and liabilities); (4) Birth certificates; and (5) Proof of Residency, etc.

  Transportation for Multiple Visits

  Childcare

- Failure to Keep Scheduled Medical Appointments

  Childcare (No Childcare)

  Must bring children to medical visit or don't make the visit. Sick children needing care at home causes cancellation of visits.

  Transportation

  Could not obtain transportation from family or father of baby. Have tokens through Medicaid but needs to travel to separate location to pick up tokens.

- Health Education

  Not aware of the value or importance of early prenatal care or preconceptual visits.

  Episodic emergency room care for crisis situations only.

  Failure to obtain family planning services (patients don't always know where to go for care).

- Drug Addiction

  Produces further disorganization to an already chaotic access process.

  Cash available utilized to purchase drugs rather than food and basic necessities.

  High rate of sexually transmitted diseases which places patient at risk for preterm labor.

  Use of cocaine places patient at additional risk for preterm labor.

- Housing

  Patients in shelters, which further disorganizes their lives.

  Living in crowded conditions with other relatives breeds unhealthy and unsanitary living conditions.

- Reduced Availability of Medicaid Healthcare Providers

  Low Medicaid reimbursement.

  Excessive paperwork and delays for payment.

  High risk medical problems.

  High cost of malpractice coverage (see attachment for documentation).

- Employment Opportunities

  No job - no health benefits.

SOME SOLUTIONS: BARRIERS TO MATERNITY CARE

- Simplification of Medicaid application process and receipt of other services, i.e., WIC, food stamps, etc.

- Presumptive eligibility - immediate access to payment for health care services during application review process for Medicaid. Presently optional by states (D.C. does not participate; Maryland does participate).

- Outreach services (Better Babies - D.C; Resource Mothers - South Carolina; Mom Van - D.C.). Childcare centers; transportation vouchers; health education (value of prenatal, preconceptual and family planning services).

- Adequate in-patient drug treatment facilities (must have childcare component while mother is in residential care).

- Housing - Immediate availability of low-income housing. Utilization of experienced and successful local housing developers expertise in renovation of present housing units, public and private, not presently occupied.

- Tort reform and recent Institute of Medicine recommendations to address the medical liability crisis.

- Job training and retention within the educational system, both males and females.

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA SURVEYS TO DOCUMENT THE MEDICAL MALPRACTICE PROBLEM

The Medical Society of the District of Columbia has surveyed its members several times in an attempt to assess the impact of the professional liability crisis on its members. The results of three of these surveys are discussed below. The first survey in August 1986 was sent to the entire active membership of the Society. The second survey, November 1987, was directed towards a high risk specialty group which has been especially hard hit by the liability crisis -- obstetricians and gynecologists (OB/GYNs). The third survey was sent to the entire active membership of the Society in June 1989. A survey of the Young Physicians Section of the Medical Society is also discussed below.

1986 District Professional Liability Survey

In August 1986, the Medical Society of the District of Columbia surveyed its members in an attempt to assess the impact of the professional liability insurance crisis on its membership. The results of the survey, culled from the responses of 1481 members, 1271 of whom then practiced in the District, provide some helpful insights.

Highlights of the survey results are detailed below. It is important to note that while the results of the survey are considered extremely reliable in that 1481 responses were received from the then 2465 active and associate members, a 60% response, survey questions were not developed by professional survey developers. Therefore, the survey is not scientific.

Results

Age and Type of Practice

The survey was sent to 2465 active and associate members of the Medical Society of the District of Columbia. 1481 persons responded, of whom 1271 were practicing physicians in the District. Approximately 85% of the respondents were male, and less than 2% were under 30 years of age; more than 75% were over 40. Approximately 76% were in a group or solo practice. Just over 33% of the respondents were in high risk specialties, such as anesthesiology, general surgery, otorhinolaryngology, plastic surgery, urology, obstetrics and gynecology, cardiovascular/thoracic surgery, orthopedic surgery, and neurosurgery.

Income and Cost of Malpractice Insurance

More than half of the respondents, 51.3%, had gross incomes of less than $150,000 and only 7% had gross incomes in excess of $300,000. Only 35.1% reported annual malpractice insurance premiums of less than $5,000 while at least 14% reported premiums in excess of $25,000.

The most common level of malpractice insurance coverage was $1M/$3M ($1 million/$3 million which means a $1 million limit per claim and $3 million aggregate per year) with 44.7% of the respondents indicating this level of coverage. This is the minimum level of coverage required to maintain privileges at most hospitals in the District. In light of the level of some recent awards, $1M/$3M may be inadequate coverage; however, adequate coverage may be unaffordable already for most physicians. Five percent reported less than $1M/$3M coverage and 4.2% reported they had no malpractice insurance coverage. (See Section 3 for indepth discussion on insurance).

Affect on Medical Practice

An overwhelming 72.3% reported that the malpractice insurance crisis had affected their medical practice in several ways. Approximately 45% indicated a change in the traditional physician/patient relationship, and almost 55% said they feared lawsuits. At least 12.0% reported discontinuing selected surgical procedures, 11.6% certain diagnostic tests and 10.8% selected medical treatment. At least 20% reported refusing high risk referrals, 8.3% said they limited new patients and 20.5% reported reducing or eliminating Medicaid or indigent care services.

A number of physicians reported other affects of the malpractice crisis on their practice. For instance, 17.6% considered moving their practice out of the District, and 3.9% did move out of the District. (This survey does not cover those physicians who left the District and therefore already dropped Medical Society membership at the time of the survey. Also the survey does not reflect the impact of new physicians who do not come to the District to practice.) Approximately 12% considered closing their practice, although only 2% actually discontinued practice. 7.5% decided not to take on a new associate or partner.

More importantly, the impact of the crisis was greatest in certain specialty areas. For instance, at least 13.6% of all OB/GYN physicians reported giving up obstetrical practice, and nearly half of them reported having had a claim or suit filed against them. Nearly 70% of all neurosurgeons have had a claim or suit filed against them, as had nearly 46% of all orthopedic surgeons.

It is not surprising that one-fifth of all physicians reported that they have reduced or eliminated Medicaid and indigent care. This percentage was highest, however, among OB/GYN physicians where nearly 44% report a reduction of services in these areas. The potential impact of this reduction of services on infant mortality rates in the District should be considered.

Refused referrals were also highest in certain high risk specialties. More than one-third of all OB/GYN physicians, and more than 31% of all neurosurgeons reported refusing referrals because of concerns about malpractice claims. More than 37% of all neurosurgeons also refused to do certain procedures out of concerns about malpractice claims.

As would be expected, the impact on consumers can be felt in doctors' fees. At least 72% of all respondents reported they had increased their fees in the past three years, and 83% said some or all of the increase was due to increases in medical liability insurance premiums.

1987 District OB/GYN Professional Liability Survey

In November 1987, the Medical Society of the District of Columbia developed a survey to assess the effects of professional liability crisis on its member obstetricians/gynecologists. It was not a scientific survey, but the results fairly accurately reflect the concerns of these physicians. 342 members were surveyed and 123 responded.

The results of questions asked of both obstetricians and gynecologists showed:

- **Obstetricians/gynecologists are moving to a practice which is exclusively gynecology.** 25% of OB/GYNs surveyed had gone from an OB/GYN practice to one exclusively gynecological. Of that number, 72% made that decision within the last five years and over 77% stated that the District's malpractice environment was a major factor in their decision.

- **Obstetricians/gynecologists are leaving the District due to the medical malpractice environment.** 15% of respondents voluntarily stopped practicing OB/GYN in the District of Columbia due to the District's medical malpractice environment.

- **Insurance companies view the District as a high-risk jurisdiction and surcharge for work done in the District.** Over 44% of the OB/GYNs practicing in both the District and in at least one other state responded their insurance company surcharges them for work done in the District.

- **Obstetricians/gynecologists are curtailing practice at District hospitals.** Over 26% of respondents indicated they voluntarily curtailed practice at a District hospital during the last two years. Almost 76% of that number indicated the District's malpractice environment contributed to that decision.

- **The District's medical malpractice environment is an important factor in decision to retire.** 12% of respondents were retired, with 75% of that number having retired in the last three years. Almost 80% of that number stated that the

District's malpractice environment contributed to their decision to retire.

The following answers were received by obstetricians who are currently in practice:

- **Many obstetricians will not practice in the District.** Over 34% of respondents did not presently practice OB in the District. Over 84% of that number stated that the cost of malpractice insurance was a major factor in their decision not to practice in the District.

- **Obstetricians are less likely to treat high risk or low income patients.** 32% of obstetricians do not accept high risk patients. 83% of the respondents do not accept District Medicaid OB patients. Of that number, 73% stated that the cost of malpractice insurance was a factor in that decision.

- **Obstetrics is a high-risk speciality.** 66% of respondents reported that at least one malpractice suit had been filed against them. Just because a suit is filed against a physician does not mean that malpractice has occurred. However, a malpractice suit must be defended, which costs money, time and emotional distress.

- **Obstetricians may discontinue practice if malpractice premiums continue to rise.** 98% of obstetricians reported they would seriously consider discontinuing practice if malpractice premiums were to increase up to 55%.

- **Malpractice premiums contribute significantly to physicians' fees.** 97% of respondents raised fees during the past two years and 90% of that number stated that malpractice insurance cost was a major factor in that decision. Over 21% responded their fee increase was a 100% passthrough of increased malpractice premiums.

- **Malpractice insurance makes cost of delivery more expensive.** When asked how much medical malpractice premiums added to the cost of each delivery, the response was as follows:
    - 6% = $200-299;
    - 11% = $300-399;
    - 9% = $400-499;
    - 18% = $500-599;
    - 17% = $600-699;
    - 8% = $700-799;
    - 6% = $800-899;
    - 8% = $900-999; and
    - over 13% responded that the cost of malpractice insurance premiums increased the price per delivery $1,000 and above.

1987 Young Physicians Survey

In September 1987, the Young Physicians Section of the Medical Society of the District of Columbia surveyed its membership in order to formulate future directions. Young physicians are defined as being under the age of 40 and/or being in practice for five years or less.

Approximately 87 percent of those surveyed indicated they found the political and economic climate of the District unfriendly to their medical practice. Thirty-six percent felt so dissatisfied with the area's climate that they would leave the District if they were not constrained in doing so. This feeling was more evident in responses from women and black physicians.

At a time when District physicians are retiring at an earlier age or leaving the District to practice, attracting young physicians is critical to the continuation of health care services. The Young Physicians survey raises serious concerns about the District's attractiveness to this category of physician.

1989 District Professional Liability Survey

In the summer of 1989, the Medical Society of the District of Columbia surveyed its members in an attempt to update the assessment of the impact of the professional liability insurance crises on its membership. The results of this most recent survey, to which 414 members of the Society responded, showed the following:

- **The District's medical malpractice environment has become an important factor in a physician's decision to discontinue practicing in this jurisdiction.** Thirty-nine percent (39%) of the respondents to the survey indicated that they have considered moving their practice from the District of Columbia because of malpractice problems and related expenses. Four percent (4%) of the respondents indicated that they had already relocated. Furthermore, of those physicians responding to the survey who indicated that they pay in excess of $30,000 per year in annual malpractice premiums (i.e., high risk practice groups and OB/GYNs), 68%

said that they had left or would consider leaving the District because of the malpractice environment.

- **The physicians who would consider leaving have practiced in the District of Columbia for a significant time period.** Of the total number of responding physicians who indicated they would consider leaving the District of Columbia because of malpractice problems, 30% had been practicing in the District between 10 and 15 years, and 27% had been practicing in the District 16 to 25 years.

- **The District's medical malpractice environment is an important factor in the decision of physicians to discontinue providing care for Medicaid patients.** Almost one-third of the respondents (29%) indicated that they would eliminate or limit the rendering of care for Medicaid patients because of the costs of professional liability insurance. Thirty-nine percent (39%) of the respondents indicated they would eliminate or limit the provision of services to the indigent or discontinue providing free care. Thirty-seven percent (37%) of the respondents indicated that they would eliminate or limit their acceptance of new Medicaid patients.

- **The high cost of professional liability insurance has caused increases in medical fees.** When asked to what degree the rise in professional liability insurance has caused them to raise medical fees, 20% of the respondents said the increase was less than five percent; 31% of the respondents raised their fees between five (5) and ten (10) percent; and 17% said they raised their fees between eleven (11) and twenty (20) percent.

Conclusions

In conclusion, although it is true that the Medical Society's surveys cannot be called scientific surveys, the responses of physicians who completed the questionnaires clearly show that concern about malpractice claims and professional liability coverage are having a major impact on the practice of medicine in the District. The impact is greatest among certain high risk specialty groups, but the spill over affect on consumers which is reflected in increased fees, more tests, reduced Medicaid and indigent care are obvious.

Chairman **Miller**. Thank you.

Dr. Burton.

STATEMENT OF WAYNE N. BURTON, M.D., VICE-PRESIDENT/CORPORATE MEDICAL DIRECTOR, FIRST NATIONAL BANK OF CHICAGO, CHICAGO, IL

Dr. **Burton**. Mr. Chairman and members of the Committee——

Chairman **Miller**. You need a microphone. You need one of the others there.

Dr. **Burton**. Thank you very much for the opportunity to share with you our longstanding efforts at the First National Bank of Chicago to provide our employees with quality and cost-effective health care.

We are especially proud of our pioneering efforts to provide the March of Dimes "Babies and You" prenatal education program for our employees and their spouses.

Our interest in prenatal care dates back to 1982. At that time we began to examine the potential causes of our rapidly rising health care costs and ways in which we might manage those costs more effectively.

We had over 10,000 employees at that time, with 60 percent women. We learned that 15 percent of our costs of health care, paid for by the bank's self-insured health plan, was related to maternity costs. Maternity costs represented our single largest area of medical care.

We also learned that of the six most common surgical procedures at that time, four were directly related to women's health.

Since Cesarean section deliveries were our most frequent surgical procedures, we decided to obtain further data in this area. In 1984, 29 percent of all of our deliveries for our employees and their depends were Cesarean section. Comparable statistics at that time for the Midwest for C-section deliveries were 19 percent.

And in 1985 we employed a part-time in-house consulting female gynecologist who was on the staff of a major university in the Chicago area.

The gynecologist utilizes space in the bank's Medical Department, which is convenient for our Chicago employees. The program is voluntary and at no cost to the employee.

The gynecologist also provides counseling for planned or current pregnancies and other health conditions, second surgical opinions, and assistance with referrals to major university centers for employees who have so-called high risk pregnancies.

Three premature births and $200,000 later, we also realized that we had to do something about newborn costs.

A healthy baby born by an uncomplicated vaginal delivery costs us about $3,000. An uncomplicated Cesarean section delivery will cost over $6,000. A low birth weight, premature baby, to so-called high tech baby, has cost us over $100,000.

So that in early 1987, to address the problems of low birth weight babies, we began offering the March of Dimes "Babies and You" program for our employees and their families.

One of the our registered nurses became a skilled instructor in the program. And today we offer a total of five one-hour lunchtime seminars, which are repeated several times during the year.

Topics covered in the classes include the importance of prenatal care, ABCs of healthy childbearing, nutrition, and exercise.

In 1989, to further encourage participation in the program, employees who complete these classes by the fourth month of pregnancy are eligible to have waived for up to one year our $200 deductible for expenses for the newborn.

Currently we're having discussions with an obstetrician to provide on-site prenatal care for our employees.

Also this year we have expanded our efforts focused on eliminating unnecessary Cesarean section deliveries by instituting a second surgical opinion program for non-emergency C-sections. Now, employees and their spouses who are scheduled to have a non-emergency C-section need to obtain a second confirmatory opinion.

We estimate that if 100 employees participate in our prenatal classes, the cost of waiving the $200 deductible for the first year of the baby's life could run at most $20,000. The cost of offering the March of Dimes "Babies and You" program is small.

There is minimal loss of employee productivity since the program is presented during the lunchtime period at work. The cost of our on-site consulting gynecologist if about $15,000 a year.

Despite these up-front costs of the incentive plan, an education program, an on-site gynecologist, we stand to save lots of money. Conservatively, if we prevent one high tech baby every five years, we can save money while enhancing care. This is a win/win situation.

In order to track the cost-effectiveness of this and other health strategies, we installed a state-of-the-art computerized program in 1987. We're tracking these costs. Within a few years we anticipate having objective data from our own program.

Our cost containment efforts, an ongoing objective, do not conflict with our goal of ensuring quality health care services for our employees. Maternal and gynecological care is an excellent example of how cost containment and improved quality of care can work together.

First Chicago's women's health program is only one of several innovative programs that we have developed to better manage the quality and cost of health care for our employees and their families.

Again, I thank the Committee for the opportunity to present First National Bank's views. And we'd be glad to answer any questions regarding our programs.

[Prepared statement of Wayne N. Burton, M.D., follows:]

PREPARED STATEMENT OF WAYNE N. BURTON, M.D., FACP, VICE PRESIDENT/CORPORATE MEDICAL DIRECTOR, FIRST NATIONAL BANK OF CHICAGO, CHICAGO, IL

Mr. Chairman and members of the committee, thank you very much for the opportunity to share with you the longstanding efforts of the First National Bank of Chicago to provide our employees with quality and cost-effective Women's Health Care. We are especially proud of our pioneering efforts to provide the March of Dimes "Babies and You" prenatal education program for our employees and their spouses.

Our interest in prenatal health and education dates back to 1982. At that time, we began to examine the potential causes of our rapidly rising health care costs, and ways in which we might manage those costs more effectively. The fact was that we had over 10,000 employees -- of whom 60% were female. We learned that 15% of the cost of health care, paid for the Bank's self-insured medical plan, is related to maternity costs. Maternity costs represented our largest and most common area of medical care.

We also learned that of the six most common surgical procedures at that time, four were directly related to women's health. These procedures included Cesarean section, normal delivery, laparoscopy and Dilation and Curettage.

Since Cesarean section deliveries were our most frequent surgical procedures, we decided to obtain further data in this area. In 1984, 29% of all deliveries for our employees and their dependents in our plan were by Cesarean section. Comparable statistics for the Midwest at that time for C-section deliveries were 18% and 19%. These numbers were also being used by a major teaching hospital in the Chicago area as a quality assurance guideline.

There are a variety of additional health risks and medical costs associated with a C-section delivery. Our average hospital and surgical, for a C-section delivery in 1984 was $6,554, nearly double the average of $3,261 for normal vaginal deliveries. In addition, an employee who has a C-section delivery is absent from work about 2 weeks longer than in the case a normal vaginal delivery. In our data analysis, we also found that 40% of employee short term disability absence days, that is absences less than six months, are related to pregnancy.

In January, 1985, as a direct result of the above data analysis, and as part of First Chicago's continuing efforts to provide cost-effective and quality health care services for our employees, we employed a part-time, "in-house" consulting woman gynecologist who was on the staff of a major university teaching hospital. The gynecologist utilizes space in the Bank's Medical Department, which is convenient for our Chicago employees. Employees are provided a periodic examination, including a medical history, blood pressure checks, blood count test, breast and pelvic examinations and a Pap smear. The program is voluntary and at no cost to the employee. The gynecologist also provides counseling for planned or current pregnancies and other health conditions, second surgical opinions, and assistance with referrals to major university centers for employees who have so called "high risk" pregnancies.

Three premature births and $200,000 later, we also realized that we had to do something about maternity costs. A healthy baby born by an uncomplicated vaginal delivery will cost us about $3000. An uncomplicated C-section delivery will cost us over $6000. A low birth weight, premature baby, the so-called "high tech baby" has cost us over $100,000.
In early 1987, to address the problems of low-birth weight birth, we offered the March of Dimes " Baby and You Program" to our

employees and their families. One of our Registered Nurses became a skilled instructor in the program. And today we offer a total of five one-hour lunchtime seminars, which are repeated several times during the year. Topics covered in the courses include A,B,C's of Healthy Childbearing, nutrition, exercise, and the importance of proper prenatal care.

In 1989, to further encourage participation in the program, employees, who complete it by the 4th month of pregnancy, are eligible to have waived for up to one year our $200 deductible for expenses for the newborn.

Currently, we are seriously considering having a part-time, onsite obstetrician to provide prenatal care for our employees. We have already had discussions with an obstetrician who is on the staff of a major Chicago area teaching hospital. And she is most interested in such a program.

Also this year, we expanded our efforts focused on eliminating unnecessary C-section deliveries by instituting a second opinion program for non-emergency C-section deliveries. Now employees and their spouses who are scheduled to have a non-emergency C-section, need to obtain a second confirmatory opinion. Otherwise the C-section will be reimbursed at the 50% level instead of the 85% level.

We estimate that if 100 people participate, the cost of waiving the $200 deductible for the first year of the baby's life could run $20,000 at most. The cost of offering the March of Dimes Baby and You Program is minimal, since one of our staff nurses is a trained instructor. It is probably less than $2000 per year. There is minimal loss of employee productivity since the program is presented during lunchtime. The cost of the onsite consulting gynecologist program is about $15,000 per year.

Despite these upfront costs of providing the incentive plan, an education program, and an onsite consulting gynecologist, we stand to save lots of money. Conservatively, if we prevent but one high-tech baby every five years we will have saved money while providing enhanced care. This is a win/win situation.

In order to track the cost-effectiveness of this and other health strategies, we installed a state-of-the-art computer system in 1987. The system tracks health care and disability costs as well as Wellness Program participation. Within a few years we anticipate collecting objective data on the impact of our prenatal program on health care costs and disability time off work.

Our cost containment efforts, an ongoing objective, do not conflict with our goal of ensuring quality health care services for our employees. Maternal and gynecological care is an excellent example of how cost containment and improved quality of care can work together. As part of our consulting gynecologist's services, we have been able to provide quality and cost-effective, periodic gynecologic examinations for our employees.

First Chicago's Women's Health program is only one of several innovative programs that we have developed to better manage the quality and cost of our health care costs.

Chairman **Miller**. Thank you.
Dr. Howse.

STATEMENT OF JENNIFER L. HOWSE, PH.D., PRESIDENT-DESIGNATE, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, WHITE PLAINS, NY

Ms. **Howse**. I'll be necessarily brief. You've heard a lot of testimony this morning about various kinds of barriers to prenatal care. Those have been documented amply in a body of reports, including the Institute of Medicine report in 1988.

I'll comment today just on the March of Dimes and a particular project organized around institutional barriers to prenatal care. The focus of the project gets to the point which you've also heard, which is: How clients are treated in the service situation matters a great deal as to pregnancy outcome and as to whether or not women are going to continue to come back for care in that setting.

The March of Dimes involvement in this program is in the context of our campaign for healthier babies. The prototype for this project was developed in New York City March of Dimes in 1987.

The "Babies and You" project that you heard described earlier is one component. Another component is our hospital project. And the purpose of the hospital project was to identify various kinds of barriers to prenatal care but, more importantly, to survey hospitals, to survey women right after delivery, and to bring together the administrators and service providers in the hospital settings to identify initiatives that were in place to address particular problems.

And for every organizational barrier that we found in the literature and that we found identified in hospitals in New York City, there was, at least in every hospital, one innovation, one initiative that could overcome that barrier in that one particular setting.

Various examples are included in my testimony. I want to emphasize again the importance of not only surveying the hospital, but also talking with women who have just gone through prenatal care and delivery in order to understand the nature of the barrier from both sides of the fence, so to speak.

After identifying these innovations, we published a series of monographs that talk about the innovations and how they are implemented. We've also sought support to carry these innovations to other hospitals in New York City and are in the process of so doing.

These innovations are nothing new. They're things that you heard this morning and that you've read in other places. Immediate pregnancy testing, expanded clinic hours, time appointment to replace this block appointment business where you have to come and wait a whole morning to get into care, free public transportation, better continuity of care, more bilingual staff, staff recognition programs, and the like.

We're now involved in the replication phase of the hospital project. We're doing it in a number of ways, including citywide conferences for hospital personnel to feature one or two innovations, have the hospital come forward that successfully implemented the innovation, and use that as a method of sharing successful techniques.

In addition to the conferences, we've also instituted a number of March of Dimes award programs so we can catch hospitals being good, so to speak, and to reward innovation where it exists.

We've also worked successfully with the New York State Developmental Disabilities Council so that public money is now being used in upstate New York to replicate the hospital project.

And I think more importantly than that all of our 130 March of Dimes chapters in communities across this country are in the process now of undertaking replication of the entire campaign for healthier babies.

And we're looking for a variety of hospital partnerships in local communities with the March of Dimes precisely to identify these kinds of innovations and initiatives that make prenatal care more user friendly.

We do look upon this. I'll adopt some text from Assistant Secretary Mason. We do look upon this as a crusade as well, and we also look upon it as a long-term problem.

If we didn't meet goals in 1990, we're going to have to do something different in order to meet goals by the year 2000.

In closing, I believe that the federal government can continue to play an important role in reducing the organizational barriers by continuing to expand coverage for uninsured pregnant women, using financial incentives to make prenatal care more user friendly, and to recognize innovative programs and to encourage their replication.

Thank you.

[Prepared statement of Jennifer L. Howse, Ph.D., follows:]

PREPARED STATEMENT OF JENNIFER L. HOWSE, PH.D., PRESIDENT DESIGNATE, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, WHITE PLAINS, NY

Good morning, Mr. Chairman and members of the Committee. I am Jennifer Howse, president-designate of the March of Dimes Birth Defects Foundation. Thank you for the opportunity to comment on reducing barriers to prenatal care.

In 1988, the Institute of Medicine issued a report that very clearly identifies the barriers that are preventing pregnant women from getting care -- financial, supply, and organizational barriers. The House of Representatives has already taken commendable action to help reduce some of the financial barriers by expanding Medicaid to cover prenatal care for women with incomes up to 185 percent of the poverty level, and by encouraging presumptive Medicaid eligibility for women seeking prenatal care. The March of Dimes hopes the Senate will take comparable action before the end of this session.

I want to talk with you today about organizational barriers. The Institute of Medicine, in its report, found "very persuasive data that institutional modification can improve participation in prenatal care substantially" and underscored "the importance of how clients are treated, what the clinic or office procedures are, and what the atmosphere of the setting is."

The March Dimes in its Campaign for Healthier Babies has found a great deal of empirical and anecdotal evidence to confirm the Institute's findings, and has identified numerous model programs where institutional changes have indeed resulted in improved participation in prenatal care.

The Campaign for Healthier Babies was first developed by the March of Dimes in New York City in 1987. As part of this program, we surveyed 38 of the city's 43 hospitals that offer obstetrical services. The purpose of the survey was to identify innovations in maternity care and develop strategies for replicating their success in other settings.

For most of the institutional barriers to prenatal care identified in the literature, we found an initiative to address the problem in at least one hospital in New York City. St Vincent's Hospital and Medical Center, for example, has a satellite clinic in Chinatown that is open on Saturdays. They've expanded their hours, and they stagger appointments every 15 minutes to reduce waiting time.

St. Vincent's has also hired two bilingual midwives -- one Spanish and one Chinese, and developed educational materials in four languages. Better continuity of care is provided through a patient tracking system that ensures patients see the same midwife each time they come in.

St. Luke's Roosevelt Hospital distributes subway tokens to all prenatal clinic patients. Woodhull Hospital Center offers on-site childcare for patients. And Lutheran Medical Center offers "quick pregnancy testing," with immediate results. If a woman tests positive, she can receive her first prenatal examination the same day.

In addition to identifying organizational innovations, the March of Dimes New York City Hospital Project also focused on patient's perceptions through in-depth, post-partum surveys at two hospitals. Interestingly, the most basic and far-reaching problem at the two institutions we studied is drugs. The post-partum surveys found powerful correlations between women who receive late or no prenatal care and drug use.

We also assessed barriers from the provider's point of view through a series of focus groups with health professionals and staff. Both the survey and focus groups have proven extremely valuable to the hospitals as an empirical source of information on prenatal barriers, and a number of new approaches have been implemented as a result.

The March of Dimes believes patient surveys are a valuable tool for identifying barriers to care at individual institutions. This approach can be applied at any hospital or clinic, and we hope more institutions with obstetrical services will follow a similar process and evaluate their maternity care services from the patient's point of view.

Based on both the hospital innovations survey and the patient survey, the March of Dimes published monographs on financial and institutional barriers to care. These were widely distributed to hospitals, clinics, and the media, and are available from the March of Dimes to anyone who is interested. Our monograph on institutional barriers recommended that New York City hospitals consider changing their clinic practices to provide the following:

1). Same Day Services -- particularly immediate pregnancy testing for walk-in patients, with prompt follow-up to schedule a prenatal care visit.

2). Expanded Clinic Hours -- to accommodate the many women who find it difficult to schedule visits during business hours.

3). Timed Appointments -- to replace session or "block" scheduling and reduce waiting time.

4). Free Public Transportation -- by distributing subway tokens or providing van service to Medicaid and state-funded patients.

5). Better Continuity of Care -- to foster ongoing relationships between patients and providers.

6). More Bilingual Staff -- to better meet the needs of ethnic populations.

7). Staff Recognition Programs -- to improve morale and motivation among clinic staff.

Having identified the barriers to care as well as innovative solutions, our objective now is to encourage replication at other institutions. One way we've sought to do this is through a New York City Hospital Awards Luncheon at which we recognize institutions that are taking steps to make prenatal care more "user-friendly."

Through a grant from the United Hospital Fund, we've also hired an extension agent to work directly with New York City hospitals in developing innovative programs. And we are holding a series of conferences in the city to educate providers about new approaches to prenatal care services.

The first of these was held last week on the benefits of combining fast-tracking of Medicaid applications, in which the clinic files for Medicaid on behalf of the patient, with presumptive eligibility, which begins in January. The conference drew more than 150 people from 43 New York hospitals.

The New York State Developmental Disabilities Council is also piloting a replication program in towns and cities in upstate New York. And the March of Dimes is to replicating the New York City Campaign for Healthier Babies on a national basis beginning next year. While the Campaign in each area will be designed around local maternal and child health needs, we hope many of our 130 chapters will forge partnerships with hospitals and work with them to reduce organizational barriers to prenatal care.

The federal government can play an important role in reducing organizational barriers to care by continuing to expand coverage for uninsured pregnant women; by using maternity care financing legislation to create incentives for hospitals to make prenatal care more user-friendly; and by using its considerable influence to recognize innovative programs and encourage their replication.

I would urge the Congress and the Administration to pay special attention to funding for specialized programs to help substance-abusing pregnant women. Crack and cocaine use by pregnant women is rising rapidly, and there is a direct relationship between drug abuse and low birthweight. Funds applied to this problem not only benefit the woman, but may save her baby from starting life critically ill, with a lengthy hospital stay and thousands of dollars in Medicaid costs.

Thank you.

Chairman **Miller**. Thank you very much.

Dr. Eberly.

STATEMENT OF JOAN EBERLY, R.N., M.P.H., DIRECTOR OF PERSONAL HEALTH SERVICES, BERRIEN COUNTY HEALTH DEPARTMENT, BENTON HARBOR, MI

Ms. **Eberly**. I'm Joan Eberly. I'm from Berrien County, Michigan. I'm across the state from Detroit, Wayne County. We're outstate. That refers to everybody who isn't Wayne County or Detroit.

I have been asked to come here and talk about the program that we had some years ago where we combined former categorical programs into one service. I will speak to four points: the advantages of coordinating services, the benefits that we encountered, and the obstacles we encountered, and the current problems we have today, a few of those in program administration at the local level.

The advantages of coordinating the service are that we were approached in 1977 to combine the former categorical—or they still are categorical—programs of WIC, Women, Infants, and Children, which is a nutritional supplemental program, through the Department of Agriculture; MIC, Maternal and Infant Care, which is primarily funded through MCH block grants; Family Planning, which is primarily Title X funding; and EPSDT, which is the Medicaid program for recipients under 21, the preventive program, and that is funded from Welfare.

The significant features of our family health project model were a single plan, a single budget, single fiscal year, one reporting system, leveling of eligibility, and integrating the staff.

We were charged to do all this to provide a single program that could provide comprehensive care retaining high quality and reducing the cost.

We implemented our program in January 1979. The benefits we experienced were: Staff was cross-trained, and they moved across program boundaries with the clients.

The clients liked it better. They had a friend going with them. They didn't encounter new staff and new programs. These services were directed toward family needs. There was greater participation in our services.

Duplication of health care services occurred less frequently. We did reduce the number of client visits. The prenatal patient got her WIC coupons during her prenatal visit. Also at her postpartum visit, the exam there became the initial exam in family planning, and she was given whatever her contraceptive choice was.

There was a higher frequency and more integrated referrals. The staff was happier. They had more variety in their jobs. We had a single agreement to go to the Board of Health and Board of Commissioners for approval.

And our cost efficiency was improved. We were one of two experimental counties, and there were two control counties. There was an evaluation by an outside agency after three years of service.

The obstacles we encountered: Administrative functions remained categorical. Funds were accounted for categorically. We did have one budget, but only after the four categoricals were rolled up into that budget.

Federal waivers to level eligibility requirements were not granted. Data remained strictly categorical. Particularly at the Michigan Department of Public Health, staff attitudes and turf issues led to a lack of commitment by most of the staff there.

Jeff Taylor, who had asked us to get into this program, was really, from our perspective, our only advocate.

The Department of Social Services continued to object to having their funding, Medicaid funding, going to support any other program, even though all the other programs were supporting EPSDT.

There was a shake-up at the state Health Department in 1985. Jeff was transferred to another bureau, and that abruptly ended our experiment.

I have been asked to relate to infant mortality as it related to our programs. I don't know whether you can see this graph, but it is included in the handouts that I have included in the materials.

This is a perinatal chart of perinatal deaths. And this is from 1970 through 1987. And, as you can see, we started our program in 1972, our MIC program. We did take a drop, and we remained lower than the state average, even though our clients are all of those at risk that you've heard so much about. We feel that we really were able to do something about having babies born okay.

The perinatal period goes from the period 21 weeks gestation until 1 week after birth.

Now here's our infant mortality. As you can see, we didn't fare as well. A lot more was happening to those kids after they were born, which really indicates that we need more support for mothers and families and babies after the prenatal period.

I do want to comment that in 1983 our infant mortality in Benton Harbor, not Berrien County—Berrien County was 16.2—Benton Harbor, was 41.9, which exceeds my friend's statistics over here. That's deplorable.

Of course, we have smaller number. So when you have smaller numbers, they can effect a jump much more quickly.

We have been receiving infant mortality initiative funds, but they come to us with strings attached: specific populations or the money must be spent only in a specific way.

What happened to us a year ago was very traumatic. On October the 18th my health officer and I were in Lansing to receive from the state Health Department the instructions for the current fiscal year. We were already 18 days into that fiscal year.

What we found out was they took our MIC grant, Maternal and Infant Care. And they took over half of those funds and put it over into a budget column entitled "Enrollment and Coordination."

We were proceeding with our staff in that grant as if it was continuation. And we had to move bodies quick. And the thing that we did, we dropped infant. We dropped our infant care program, which handled children up to five years of age.

The state was able to double their prenatal funds from the government, but those funds came saying that you can't use those funds for direct patient care. And that's what we were doing.

I think I've exceeded my time. I would like to say something about AIDS, and maybe you'll ask us about that later. I've been practicing to get it in five minutes, and I don't think I managed.

[Prepared statement of Joan Eberly follows:]

PREPARED STATEMENT OF JOAN EBERLY, R.N., M.P.H., DIRECTOR OF PERSONAL HEALTH SERVICES, BERRIEN COUNTY HEALTH DEPARTMENT, BENTON HARBOR, MI

INTRODUCTION

Berrien County is located in the extreme southwest corner of Michigan, bordered by Lake Michigan to the west and Indiana to the south. The County's strategic location along Lake Michigan between Detroit and Chicago is the juncture of major federal highway systems. The metro county of Berrien consists of 39 municipalities, 22 townships, 8 cities and 9 villages, the principal cities of Benton Harbor and St. Joseph, employ a Mayor/Commissioner, City Manager form of government. The third, Niles, has a city council/administrator form of government.

The county has experienced a decline in population from the 1980 census 171,276 to 163,600 primarily due to employers closing their manufacturing plants and one moving their administrative headquarters to other states. A major accomplishment was realized in January 1986 when Benton Harbor was officially established as a Pilot State Enterprise Zone. The designation is designed to infuse investment capital in the city through tax breaks and other incentives.

Berrien County's gently rolling topography rises to 200 feet above the level of Lake Michigan on high bluffs. There is an abundance of farms, woods and inland lakes. The largest non-citrus cash-to-grower market in the world, and numerous food storage and processing plants are evidence of the importance of agriculture to the Southwestern Michigan area. Historically agriculture has been a major contributing factor to the local economy, adding to its diversification. The 184 day growing season with its ideal temperatures and humidity along with the moderating effect of Lake Michigan make this possible. The orchards and vineyards attract thousands to the area every year.

Tourism is now one of the major economic factors. Recreational opportunities abound in Southwestern Michigan. From snow to water skiing, boating, ice fishing, swimming, snowmobiling or maybe hang-gliding. The area boasts 50 parks, 4 playgrounds and 14 public beaches and parks along the 42 miles of Lake Michigan shoreline. The St. Joseph River, Michigan's 2nd longest, affords 23 miles of navigable waters with 16 access points in Berrien County. The legendary 30 lb. Chinook Salmon is a reality here in the big pond (Lake Michigan) along with abundant Coho Salmon, Lake Trout, Brown Trout, Perch and Steelhead. Berrien County has nearly 2,000 acres of recreational land.

The St. Joseph River separates the two major cities of St. Joseph and Benton Harbor. It separates the wealthiest community from the poorest; per capita income - St. Joseph - $13,996.; Benton Harbor - $5,514. (1986). A Department of Commerce "Need Index Ranking" ranked Benton Harbor #1 of 1,601 Michigan communities in 1982. This is the site of our main health department facility.

* * * * *

I am here to talk to you about our Family Health Program (note the brochure in your packet) which began in 1979. I speak to you from the perspective of a local health department about our experience in coordinating services that are usually delivered on an independent basis and in some situations they stand alone.

In late 1977 Dr. Jeffery Taylor, Materal and Infant Chief of the Michigan Department of Public Health, gave us the opportunity to be one of two local agencies to implement the Family Health Project Model, which grew out of two of his prior research projects. They had identified weaknesses in traditional, categorical programs for serving low income mothers and children. The Family Health Project Model called for an integration of four categorical programs - WIC - Women, Infants and Children, MIC - Maternal and Infant Care, FP - Family Planning and EPSDT - Early Periodic Screening Diagnosis and Treatment - into a single multi-service program. Significant features of the model included: single plan, single budget, one fiscal year, unified reporting system, generalized consultant from Michigan Department of Public Health, leveling of eligibility, integrated clinic and cross-trained staff. In short, the intention was to create a single program which could provide comprehensive, high quality health care at low cost.

One of the main disadvantages with categorical programs has been that by focusing on a single, well-defined health problem, there is the potential for missing broader health issues. In their most strict form, categorical programs ignore the existence of all other services in both day to day operation and long-term planning. This happens in spite of the fact that they often serve the same people and provide similar, potentially interrelated, services. Staff from one program cannot assist in another program, despite periodic changes in workload; there may be a duplication of services when a person is a participant in more than one program; financial eligibility may vary so that individuals who qualify for one program may not qualify for another; and there is often a duplication in reporting when two or more programs need the same information.

We had experienced many of the above disadvantages as we implemented Family Planning, MIC, EPSDT and WIC during the early 70's. We began our Family Planning Program in 1969. As with any start-up program, there was down time. We became involved in prenatal care in the early 1970's because many poor women were unable to find physicians who would accept them into their practice. At this time, the Family Planning Program was in its' formative stage; thus, the staff were not fully utilized for family planning services so the health department chose to use this resource to respond to another public health need - prenatal care for poor women. Region V family planning officials objected strongly to this course of action and disallowed further use of family planning staff for prenatal care. An appeal was made to the Michigan Department of Public Health for funding to provide prenatal care. A small grant was made available in the late spring of 1972, and was followed in December of 1972 by a maternal grant for comprehensive prenatal care which included nutrition, social and health education services, as well as the traditional medical and nursing services. The infant component of our Maternal and Infant Program was funded during 1974. Our EPSDT Program began in the Spring of 1973 and WIC began in the Spring of 1975. Our programs were delivered categorically and were serving many of the same individuals and experiencing the duplication of efforts. In an effort to address these problems, the Maternal and Infant Care Division of the Michigan Department of Public Health chose two county health departments in Michigan to undertake this project; one was Berrien, the other was Muskegon. Kent and Saginaw Counties agreed to serve as the control counties, meaning that they would keep their programs as categorical, and be used for comparison when the Family Health Program experiment was evaluated.

In creating the Family Health Program, it was hoped that this integrated approach would more effectively and efficiently meet the health care needs of the families in Berrien County. The goal of the program was to deliver comprehensive health care services in a way which treats the family as a whole and not as fragmented parts. Referrals were often made to appropriate services within the Family Health Program, and staff crossed program boundaries with clients to insure continuity of care. The Family Health Program also integrated with other health department and community services that both the staff and the family felt could address their health needs. Staff working in the program included nurse practitioners, registered nurses, physicians, nutritionists, social workers, a health educator, laboratory technicians, vision and hearing technicians and clerks. We used the team approach in all program.

We spent over a year in preparation - cross-training staff, developing a single form where possible, i.e. intake form, developing the process of reducing client visits to meet their total health needs. While our services were largely designed for mothers, infants and children, we welcomed fathers and significant others and included them in our care plans and educational sessions. In January of 1979, both counties implemented this new program. To describe our basic services, I am using a report that was written late in 1983 that also includes the evaluation of the Family Health Program.

BASIC SERVICES OF THE FAMILY HEALTH PROGRAM

Prenatal

The Prenatal program provides comprehensive prenatal care to low income women who have at least one maternal high risk factor. A woman is considered to be high risk if she has, or is likely to have, conditions associated with childbearing which increase the hazards to the mother or baby. Components of the program include medical care, social work counseling, nutrition counseling, education and environmental assessment.

The delivery of a healthy infant by a healthy mother is the overriding goal of the Prenatal program. This is often measured in terms of the perinatal death rate, which is the number of infant deaths from the 20th week of pregnancy to the seventh day of life per 1,000 births. In 1983, Berrien County's perinatal death rate was 12.94, compared to 13.53 for the State of Michigan. Although the health department does not give prenatal care to all the women in Berrien County, it is hoped that the provision of comprehensive services to high risk women contributes to the county's lower rate. In 1983, 529 women received prenatal care through Family Health Program and there were 337 deliveries. Prenatal services are offered at the health department's Benton Harbor office and also at Berrien General Hospital.

In September of 1983, a Teen Prenatal Clinic was started to meet the special needs of pregnant teenagers. Last year in Michigan, births to teenagers 19 and younger accounted for nearly 13% of all births. In Berrien County, close to 20% of all births were to teenagers. This statistic clearly points out that adolescent pregnancy in our county is an issue which must be addressed.

The Teen Prenatal Clinic is held in the late afternoon so there is no need for a disruption of school during the day, and patients are seen more often since they are at higher risk. The education component is geared towards the specific needs of teens, and the follow-up on the patients is more intense. From September 1, 1983 to August 8, 1984, 111 teens were given care through the teen clinic and there were 60 deliveries.

Another program that is relatively new is the Parenting and Infant Care class - a health class for pregnant teens at Benton Harbor High School. This was started in January of 1983, and thus far 60 students have participated. The health department is contracted by the Benton Harbor school system to provide this class on a daily basis. Students who enroll and successfully complete the course receive credit towards their high school diploma. Examples of topics covered include prenatal nutrition, anatomy, fetal development, labor and delivery, venereal disease, contraception, infant care and infant growth and development.

Infant

The Infant program contains two major components. One is a "Special Needs" Well Child clinic and the other is the Community Parenting Program. The Special Needs clinic is for infants and preschoolers with an identified risk who could benefit from well child care through the team approach. A requirement of the program is that participating families have an identified family physician to whom they can be referred in the case of illness. The emphasis remains on serving children of families who are at high risk and/or those who cannot afford well child care from other clinics or the private sector. Babies born to moms in our Teen Prenatal Clinic are a good example.

They are strongly encouraged to participate in the Infant Program and are closely followed for the first year. Services provided through the Well Child Clinic include assessment of growth and development, general physical exam, immunizations, counseling on parenting skills and referrals for problems. Clinics are held once a week at the health department's office in Niles and three times a week at the Benton Harbor office. In 1983, 253 children from birth to five years of age were seen in the Well Child Clinic.

The Community Parenting Program is a series of parenting classes designed to help parents be more effective in caring for their children and in meeting the demands of parenthood. The series contains five "modules" which have been developed for specific age groups from birth to five years. The modules which make up the Community Parenting Program are: 1) Newborn Expectations (birth - 3 months); 2) Early Infancy (3 - 9 months); 3) Late Infancy (9 - 20 months); 4) Toddler Years (20 months - 3 years); and 5) Preschool (3 - 5 years). The classes are taught by a pediatric nurse practitioner, a social worker and a nutritionist, all of whom have expertise in the filed of child care and parenting. The modules are offered monthly at the health department's Benton Harbor office. They are also held periodically at various other locations within the county, such as Pawating Hospital, Lake Michigan College and the YWCA in St. Joseph. In 1983, 64 parents participated in the Community Parenting Program. All county residents are eligible to enroll in these classes; the only requirements are the desire to learn and an interest in children.

Women, Infants and Children Supplemental Food Program (WIC)

WIC is a program for pregnant women, nursing mothers and infants and children up to five years of age. To qualify for this program, the mother or child must have a medical or nutritional risk factor and they must meet income requirements. The WIC program provides education and counseling about nutrition and meal planning during periods of life when good nutrition is the most critical - pregnancy, lactation and early childhood. Intensive counseling is done on a one-to-one basis and education is provided in a group setting.

Another component to the WIC program is the provision of coupons to eligible persons for certain supplemental foods needed during these critical times. WIC foods are not intended to make up the total diet; rather, they add to the foods that participants should already be eating. Only foods that have the right amounts of certain nutrients are used in the program. Examples of the kinds of foods chosen are milk, cheese, juice, eggs, cereal and infant formula. Others are also included.

The goal of the program is to improve the nutritional status of pregnant women and nursing mothers so that they will be healthy and their babies will be off to a good start in life. It also aims at bringing up the nutritional status of participating children to a level where they no longer need the program. Establishing lifetime habits of good nutrition is the main tool for accomplishing these tasks. The WIC program is closely linked to the Prenatal and Infant Programs. Last year, WIC serviced 2,052 individuals.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a preventive health program which provides for early detection of health problems and referral for treatment when necessary for Medicaid eligible persons under the age pf 21. The health department carries out the *screening* component to this program, and referrals are made to appropriate providers for diagnosis and treatment. Those who participate receive a physical assessment (which includes a check on vision and hearing), developmental testing, sickle cell and lead screening and counseling. The program is designed to encourage *preventive* health care for those who might otherwise wait to visit a doctor until a serious illness is apparent. There is an outreach component through which calls are made to inform eligible persons about the program and to encourage them to participate. Transportation is provided when necessary. In 1983, 3,969 individuals were screened in the program.

Family Planning

This clinic offers a variety of family planning services to persons wishing to choose the size of their family and spacing of their children. Persons eligible to participate include those who meet income requirements, have problems of accessing other family planning services or have the risk of a problem pregnancy. The program is run on a fee-for-service basis (participants pay according to their income), but no one is denied service. The program includes pregnancy testing, education and counseling on reproductive health and the provision of contraceptive services. Social work and nutrition counseling are available when needed. A total of 3,907 patients were seen in the Family Planning Clinic in 1983.

EVALUATION

In order to gain an accurate picture of the impact of the Family Health Program Model, a systematic program evaluation effort was initiated during the fall of 1982. The Michigan Department of Public Health contracted with University Associate, a private research firm, to conduct the evaluation. The objective of the evaluation was to assess the degree to which the programs were actually consolidated, to determine the strengths and weaknesses of the Family Health Project Model and to make recommendations regarding future implementation in other Michigan health departments. The

Family Health Programs of Berrien and Muskegon Counties were compared to the two control counties, Kent and Saginaw. All four health departments were considered similar except for the Family Health Program which was operational in Berrien and Muskegon. Seven major areas were addressed in the evaluation: 1) degree of implementation; 2) comprehensiveness of health care; 3) quality of health care; 4) administrative ease; 5) cost efficiency; 6) staff satisfaction; and 7) client satisfaction.

The evaluation showed that partial implementation of the Family Health Program model has been achieved. Total adoption has been hindered by federal and state requirements that conflict with this model. Those implementation components that local health departments have the ability to control have been more fully implemented. The Family Health Program has been found to offer comprehensive health care to the extent that it provides more services directed towards the needs of entire families. More specifically, greater participation across services has occurred. Training of staff to work in all four programs has probably contributed to this happening.

Another finding was that duplication of health care services occurs less frequently; this had been one of the primary goals when the Family Health Program model was created. Finally, the Family Health Program approach was found to be more cost efficient than the categorically run programs. It was found to have lower costs per unit of service.

Advantages of the Family Health Program were:

- staff became "total patient needs oriented" - improved ability to staff clinics in times of personnel shortages due to sick leave, vacations, reduced staff, etc.
- clients happier with reduced clinic visits - i.e. WIC coupon pick-up during prenatal visits
- staff reductions and savings of taxpayers dollars were achieved through more efficient use of personnel while maintaining same caseload. (Instead of four program coodinators ... we had just one.)
- total patient (integrated) health education was more effective and natural
- high achievers in old individual categorical programs now influence other programs to be high achievers
- coordination of family health referrals with public health nurses has been easier to facilitate

- potential to reduce paperwork ... i.e. one screening tool consisting of basic patient information rather than filling out up to four screening tool forms for different programs
- better morale in that patients' needs are put ahead of old fashioned excuse of "it's not in my job description to do that work!"
- we believe that "generalisation" by staff is a superior system to staff program specialisation
- instead of approaching our Commissioners with four agreements and four resolutions, could get Board of Health and Commissioner approval with one agreement and one resolution
- generally, only one program plan needs to be written ... not four
- staff is happier in their jobs as variety of work creates interest and replaces rate performance
- more opportunities for advancement in that a larger career ladder has been created
- better coordination now exists between clinical personnel and clerical

A list of obstacles we encountered were:

- Administrative functions remained categorical.
- Funds were accounted for categorically.
- Eligibility requirements remained categorical.
- Added work in budgeting was required as a summary budget needed to be drafted.
- Data reporting remained strictly categorical.
- Lack of unified reporting system.
- Staff attitudes - turf issues - lack of coordination and communication at Michigan Department of Public Health.
- Lack of understanding of concept - lack of commitment at Michigan Department of Public Health.
- Department of Social Services/Michigan Department of Public Health relationship to EPSDT funding.

From our perspective, Dr. Taylor was the only advocate for the Family Health Project at Michigan Department of Public Health. He was transferred to another Bureau in 1985 and we were abruptly forced back into the categorical model. This was disappointing to us and hard for our staff to accept.

I have been asked to comment on our infant mortality rate in relationship to our services. In the packets I have provided are perinatal and infant mortality statistics from 1970 thru 1987 and two papers that identify problems we have traditionally had in providing prenatal care for poor women in Berrien County. We feel our prenatal and Family Health Program services have contributed to the decline in the mortality data as our clients have been from the at risk population. The perinatal rate is more sensitive to prenatal care and you can note that for most years Berrien County was below the Michigan rate. Mortality rates are generally higher for the low socioeconomic portion of the population. Perinatal mortality (deaths occurring from 20 weeks gestation through 7 days after birth) is a measure of this increased risk. The perinatal mortality rate is known to be high in the low socioeconomic group and especially for teenage mothers. The rates for blacks are generally double the rate for whites. Because our I.M.R. (Infant Mortality Rate) was high, we were one of the first four "out state" (Detroit was one of the large urban areas federally funded in the 60's) to receive funding for prenatal care by the Michigan Legislature in 1972. The largest percentage of our prenatal clients reside in the Benton Harbor area. Many of them minority (80%) and adolescents (38%). Benton Harbor has been a depressed area for many years since the white flight of the 60's and early 70's. Money magazine rated Benton Harbor at the bottom of a list of the 300 worst cities to live in America in the September issue. The Wall Street Journal has featured Benton Harbor's depressed state. Until the illegitimate rate was no longer a published statistic, Benton Harbor's rate was among the highest in the nation. We feel quality health services are a must if we are going to continue to reduce the Infant Mortality in our county and in Michigan.

Where do we stand today? We have a proliferation of budget columns with each requiring program plans and reporting requirements. The trend seems to be for more restriction in funding. It is more difficult to administer program delivery on the local level.

Since 1985, Michigan has directed new dollars toward providing prenatal care for poor women in an effort to reduce infant mortality. This past year, Medicaid coverage has been extended to 185% of poverty for pregnant women. This has been a tremendous step forward in providing care for poor women. We are, however; concerned that our active caseload of prenatal patients has gone from 584 to 1,389 in the five years since 1984 while at the same time our Family Planning state funding has gone from $264,615. to $156,116. This is a backwards step in our program to reduce infant mortality. The state of Michigan is taking a $500,000 family planning cut in federal funding and are passing a 9% reduction to all local agencies. Another factor which may adversely affect the infant mortality rate is that Medicaid no longer will pay for abortions in Michigan. We in Berrien County have been targeted as one of fourteen Michigan counties to receive funds to reduce the infant mortality rate. However, instead of providing for coordinated programming, these funds come with specific restrictions as to their use and accountability, which makes it more difficult to for locals to provide coordinated family oriented services.

Bottom line - we need more flexibility on the local level so that we may more effectively and efficiently meet the health care needs of our families. We would welcome the return of our Family Health Program.

Chairman **Miller**. Well, you're close. You get a star.

Ms. **Eberly**. Good.

Chairman **Miller**. A report from the front, so to speak.

Ms. Ruscitto.

STATEMENT OF KATHY RUSCITTO, COUNTY ADMINISTRATOR FOR HUMAN SERVICES, ONONDAGA COUNTY, SYRACUSE, NY, ACCOMPANIED BY JAMES MILLER, M.D., COUNTY HEALTH COMMISSIONER, ONONDAGA COUNTY; CHAIRMAN, NEW YORK STATE HEALTH COMMISSIONERS ASSOCIATION, SYRACUSE, NY

Ms. **Ruscitto**. Thank you, Mr. Chairman. In deference to your needing to get to the floor, I will be as brief as possible. I represent——

Chairman **Miller**. I cannot run that fast, so relax here a second.

Ms. **Ruscitto**. Onondaga County, which I represent today, is located in upstate New York and has a population approaching about 475,000 people with about 70,000 located in the City of Syracuse. It is not unlike many of the midsize counties, and I'm sure are represented by members of this Committee.

We had a problem in our community that between 1985 and 1987 the number of infant deaths per 1,000 resident births rose from 13.7 to 17.8 percent.

We at that time felt very strongly that we needed to move quickly. We needed to not wait for any further changes from federal or state government in terms of categorical programs, but we needed to do something very quickly on a local level to begin to respond to those statistics.

In 1988 our community began to tackle this problem by developing an access to health care committee that is looking at a whole number of issues, but particularly focused on the issue of infant mortality.

And we chose to do that by initiating something called a community-based comparison. Literally, we looked across the United States for another community with the same demographics as our community, but with less than half the infant mortality rate that we had. And we found that community. It was Toledo, Ohio.

At that point in time I sent a team to Toledo to look for a couple of days at their entire service structure to see if we could not detect some very key differences between the way we delivered services and the way they delivered services.

And we found substantial differences, and they primarily related to the coordination and the integration of services.

From that experience as well as a second visit made by Commissioner Miller, who is with me today, our Health Commissioner, to Hartford, Connecticut, we have developed and are implementing a series of recommendations that we feel are going to change the rates that I just spoke to you about related to infant mortality.

And let me very briefly describe to you just some of the highlights of those issues. First of all, I have directed all of our human service commissioners by the close of 1990 to present one consolidated plan regarding maternal and child health to report to the state in a number of different categorical programs. But we will develop for our community one consolidated plan.

Secondly, we are going to work with our state government to try to reduce the duplication of services, as they are currently being provided. And that's going to take a whole number of forms and frames as we go forward.

We're developing a task force on coordinated human services to bring together all the players in the system and make sure everybody is talking to everybody on a monthly basis, if not a weekly basis, and on a formal level.

The thing that we are doing that we are most excited about is to begin to provide WIC and Medicaid enrollment at free-standing ambulatory clinics as well as hospital clinics in our community.

When we visited Toledo, again, one of the big differences we saw is if you look at their hospitals and their clinics, social services exist within those clinics. And when a woman walks in the door, she receives the full array of services.

We will this spring be moving into a hospital-based clinic with all of our human service programs. And when a woman walks in to receive her prenatal care, she will receive those additional social service supports as well.

We are talking with the hospitals in our community about expanding their existing hospital-based and ambulatory care programs and ensuring that there are evening and weekend hours available to women.

We are working on the development of a specific mechanism for follow-up with at-risk women and children who miss appointments. I think you've heard it this morning. I think it's very important that we be very, very aggressive with that population, and we intend to do so.

We are working with our community college and our Department of Social Services in developing a pediatric outreach worker program. We are going to have a career ladder related to home health aides in our community with the peak of that ladder being a pediatric outreach worker that is going to be offered through our community college.

We are looking very strongly at transportation services. In Toledo, we found that there was a very broad authorization for the use of Medicaid taxes and the use of the public transportation system related to call-a-bus programs to ensure that once a woman is identified at high risk, she gets whatever authorization she needs to get to those appointments. And it's the broadest possible authorization. And we're going to make sure that happens.

We looked at a number of different other areas, but I think the one area that encompasses many of the other recommendations relates to home visits. Again, in Toledo, we found that they were very aggressive about getting into the homes of high risk women and following them through the first year of their pregnancies. And we are working with our public health nursing program to ensure that happens.

We have talked with the businesses in the health community. We are looking at the development of a mechanism to provide health insurance for pregnant women who are not eligible for Medicaid and for whom no other insurance is available due to economic constraints.

And, finally, there is going to be very strong involvement with our business community looking at doing a very broad public-private partnership in fighting infant mortality in the coming years.

As I've said to you, I've spent a lot of time talking about coordination and integration of services, what we've seen that has worked in other communities, and it's proven by the fact that in one particular community, where their infant mortality rate was literally half of ours, they have been able to keep that level down and make a difference.

Let me be very clear. In order for there to be proper coordination in our community and other communities, there has got to be a change in the way we offer our human service programs. They must be delivered through clinics, schools, and hospitals. They cannot be separate free-standing programs.

We are looking also in our community at bringing together, with the state government's help, a number of other projects that will help us focus on that population.

We know that in the short run, some of the changes that we're looking at making are going to cost more, but we feel in the long run, we have no other choice.

And I thank you very much for inviting us.

[Prepared statement of Kathy Ruscitto follows:]

PREPARED STATEMENT OF KATHRYN H. RUSCITTO, COUNTY ADMINISTRATOR FOR HUMAN SERVICES, ONONDAGA COUNTY, NY

Good morning. Mr. Chairman, Congressmen, thank you for the opportunity to address you this morning. I want to spend just a few minutes describing my community, our problem and our responses to that problem before answering your questions.

Onondaga County is located in Upstate New York, and has a population approaching 475,000, with 170,000 located in the City of Syracuse. It is both an inner-City and rural community, and it is culturally diverse. It is not unlike many of the midsize counties that you represent. It is a community rich in social and cultural activities; yet is struggling with a major health care problem, infant mortality. Between 1985 and 1987, the number of infant deaths per 1,000 resident births in our inner-City rose from 13.7 to 17.8. In the same period, the number of deaths in the County per 1,000 rose from 9.5 to 11.9.

Within the United States, infant mortality varies by region and state. The causes of infant mortality have been the subject of extensive discussion, but it is generally conceded that this condition is associated with race, poverty and teen pregnancy. The linkage between infant mortality and poverty is largely based on access to prenatal care. In addition young maternal age and teen births have also been linked to infant mortality.

In 1988 our community began to tackle the issue of access to health care. County Executive Nicholas Pirro appointed a Task Force including hospitals, physicians, nurses, social service and health providers, and insurance companies to review:

- maternal and child health care
- Medicaid accessibility
- clinic availability
- homeless health care services

As the Committee examined in data maternal and child health care, in particular the infant mortality data, it chose to initiate a community based comparison. Simply put, we looked across the United States for a community with similar demographics, but with a lower infant mortality rate. At the same time with the help of the New York State Department of Health we initiated a case by case review of all infant deaths for 1985-1989, as well as prospectively. The Committee felt a community based comparison would perhaps move us along more quickly and help us to see if the problem was structured.

Our team spent two days in Toledo, Ohio (Lucas County) and the visit was invaluable. From that trip as well as a visit to Hartford, Connecticut we have reached a number of conclusions. I will highlight only a few that are currently being implemented in our community.

Recommendations

BROAD

A. Maternal and child health must become a center piece for consolidated plans

B. Federal and State government should encourage enhanced coordination to reduce service delivery duplication

C. Policy initiatives placing a priority on maternal and child health care must come from the highest levels of government, but allow for local implementation

COMMUNITY BASED

A. Development of a Task Force for Coordinated Human Services. Leadership would be provided by the Commissioners of Health and Social Services, and include public/private representation. The purposes of the Task Force would include identification of needs in the human services, coordination of existing services, and development of recommendations concerning new services, if appropriate.

B. Establishment of a designated Staff Coordinator to ensure continuity of programming which addresses the needs of at-risk women and children, as well as accountability for the results of such programming.

C. Encouragement of the assessment of existing educational programs for at-risk women and children and the identification of gaps in the curriculum.

D. Provision of WIC and Medicaid enrollment at freestanding ambulatory care centers and hospital clinics in the community through contractual arrangements with Onondaga County government.

E. Expansion of existing hospital-based and ambulatory care programs of patient care and follow-up for at-risk women and children at St. Joseph's Hospital Health Center, Crouse Irving Memorial Hospital, and the Syracuse Community Health Center, to include additional education and social services, as well as increased follow-up after inpatient discharge.

F. Development of a specific mechanism for follow-up with at-risk women and children who miss ambulatory care center or hospital clinic visits. This mechanism should include personal contact with clients, as well as telephone and written communications.

G. Evaluation of the potential for additional evening service to at-risk populations by freestanding ambulatory care centers and hospital clinics. As an interim measure, Onondaga County Health Department clinics should be scheduled during late day and evening hours.

H. Encouragement of The Caring Program for Children Foundation which will provide health insurance for children for whom this coverage will otherwise not be available.

I. Evaluation of current practices for provision of transportation to clinic and ambulatory care center appointments for at-risk women and infants and identification of an alternative mechanism that would be more comprehensive and efficient.

J. Development of an assessment of the relationship between infant mortality and the use of drugs in Onondaga County and identification of potential approaches to this problem.

K. Consideration of the potential for a system for management of social and health care for at-risk women and children.

L. Integration of the findings concerning infant mortality identified by the Cradle to Kindergarten Task Force, the Syracuse Commission for Women and representatives of social and health agencies, as well as an action plan to address this problem in Onondaga County by the Task Force for Coordinated Human Services.

M. Support for the extension of parenting and family life education programs throughout the schools of Onondaga County beginning at kindergarten. This effort should include programs which address gaps in existing services identified in the short term assessment.

N. Development of a comprehensive, County-wide awareness program to inform at-risk women of the need for prenatal, postnatal, and child care and of the existing services.

O. Evaluation of the feasibility for developing a dairy delivery program for WIC services in Onondaga County.

P. Development of integrated hospital-based programs including effective follow-up for at-risk women and children at St. Joseph's Hospital Health Center and University Hospital-Crouse Irving Memorial Hospital.

Q. Expansion of the capacity of existing programs that provide support and follow-up to at-risk women and children such as Teen Babies and the Teen Age Services Act (TASA) programs.

R. Development of a field counselor training program to provide follow-up home visits for at-risk populations through existing providers, as well as a career ladder for homemaker home health aides.

S. Development of a mechanism to provide health insurance for pregnant women who are not eligible for Medicaid and for whom other insurance is not available due to economic constraints.

T. Involvement of the business community of Onondaga County in specific efforts to address the local infant mortality problem through a public/private partnership.

These recommendations largely focus on integration and coordination of services. They do not recognise categorical funding requirements. "Coordination is a value, it recognizes the necessities of centralized controls as well as decentralization in local service delivery."

Unfortunately, many of us are vague when we discuss coordination. Let me be clear, our social and health services must be delivered through our clinics, schools and hospitals. Categorical programs cannot be offered in eight locations, with eight application processes with multiple requirements for a poor mother with small children in tow. It is too easy for her to dismiss the return appointments with predictable results.

Recently a mother in our community delivered her fourth low birth weight baby. It remained in intensive care after her discharge and the infant did not receive any visitors. When confronted by a reporter about her lack of concern she responded that she did not feel well, had no child care for the other three children, and could not handle two changes on public transportation with infants. Somehow we must arrange our services so that we can reach that mother.

Onondaga County government and a local hospital are moving in together. We will be asking our State for help in many areas, and be looking at how to best impact the women we encounter. Will it cost more? Perhaps, in the short run, but long term the cost savings are incalculable. For our community we have no other choice.

Thank you.

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2) "Delivering Children's Services: The Experience of Ulster County"; Gerald, Benjamin; Caring for America's Children; N.Y.: 1989

3) "Planned Change in the Mon Valley: Implementing Services Integration at the Programmatic Level"; Farrucci, Dennis; 1977

4) "State of the Child in N.Y.S."; N.Y.S. Council on Children and Families; 1985

5) "Prenatal, Delivery and Infant Care Under Medicaid in Three States"; Howell, Embry and Brown, Gretchen; Health Care Financing Summer, 1989; Vol 10, # 4

6) Brecht, MC: The Tragedy of Infant Mortality, Nursing Outlook 37:18

Infant Mortality in Onondaga County

Statement by James R. Miller, MD, MPH
Commissioner, Onondaga County Health Department
President, New York State Association of County Health Officials
October 24, 1989

The key findings from our current study of infant mortality in Onondaga County are as follows:

- During 1980 - 1987, overall infant mortality has been reasonably constant, with normal year-to-year fluctuations.

- The risk of mortality to infants born in the City of Syracuse is consistently about double that outside the City.

- Infant mortality for blacks in Syracuse and the entire County is nearly *triple* that of white infants (Risk ratio = 2.8).

- Contrary to nearly all national and state trends, black infant mortality appears to be *increasing* over this period.

- Much of the recent increase in black mortality appears to be concentrated in the post-neonatal period (1 month to 1 year). During 1981 - 1983, the risk of neonatal mortality was about double that of the post-neonatal period, for both races, as is commonly found in state and national statistics. Since then, however, whites have remained at that level, whereas post-neonatal black mortality has risen so that it now equals neonatal mortality.

- Comparative data on risks of infant mortality for 17 large cities, including New York City, Boston, Detroit and Philadelphia has recently become available for the 1983 data year. In comparison to these cities, Syracuse had *the highest* black infant mortality of all. Because Syracuse ranks third from the *lowest* in white infant mortality, the risk ratio of blacks relative to whites also is the worst of these cities.

- Comparison with international figures are also startling. A black child born in Syracuse is less likely to survive to one year of age than a child born in Jamaica or Costa Rica.

- At this juncture, the reasons for the elevated black infant mortality are not clear. Certainly, some of the problem is associated with teenage pregnancy. While about 14% of live blacks births are to teenage mothers in our County, 24% of post-neonatal black mortality occurs with teenage mothers. That, and the fact that the ratio of neonatal: post-neonatal mortality is badly skewed in black teenage mothers (2:3 ratio, versus the stereotypical 2:1 ratio) suggests that black teenage pregnancies should be a major focus of prevention efforts.

- An analysis of census tract-level data revealed that low birth weight (LBW), late/no prenatal care and prematurity are the primary associates of differences in IMR among Onondaga County census tracts. Comparisons of black and white infants using birth certificate data indicate that on average, black infants are at significantly greater risk of LBW, late prenatal care, and prematurity than are their white counterparts.

Figure 1

Infant Mortality, Onondaga County
1978-1987

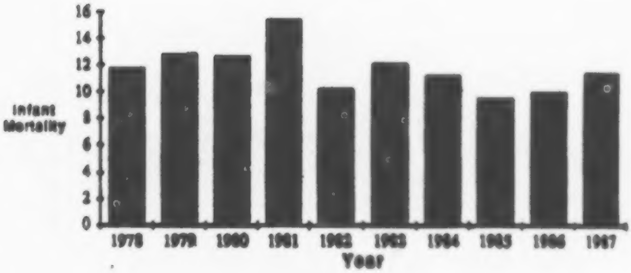
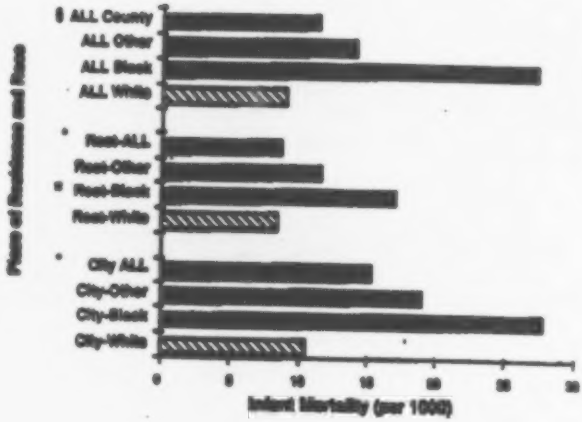


Figure 2

Onondaga County Infant Mortality
-- By Place of Residence and Race --



Notes:
Graph prepared by OCHD Surveillance Program
based on data provided by NYS Department of Health,
Vital Records Bureau.
* City vs. Rest of County analysis for 1981-1986 only.

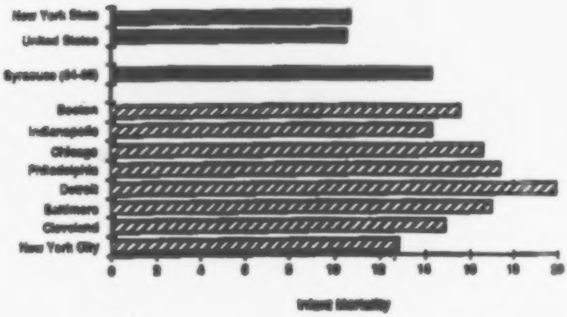
§ All County statistics include 1987 data.

¤ Small sample size. Number should be interpreted with caution.

Figure 3A

Infant Mortality for Syracuse Relative to other Cities, 1985.

A. Infant Mortality for All Races



Notes

Data for other cities, New York State, and United States from The Maternal and Child Health Data Book. 1988. Children's Defense Fund.

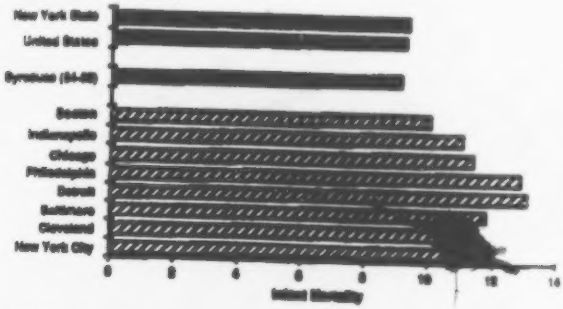
Syracuse data from NYS Health Department Vital Records.

Analysis and graph by Bureau of Surveillance & Statistics, Onondaga County Health Department.

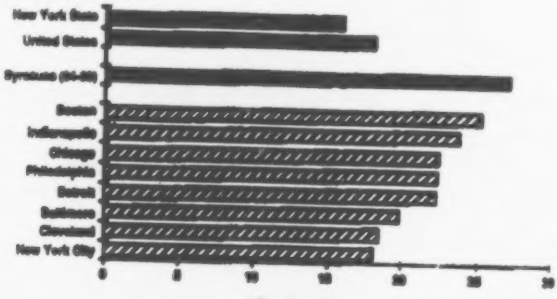
Figure 3B and C

Infant Mortality for Syracuse Relative to other Cities, 1985.
Infant Mortality by Race

B. White Infant Mortality



C. Black Infant Mortality

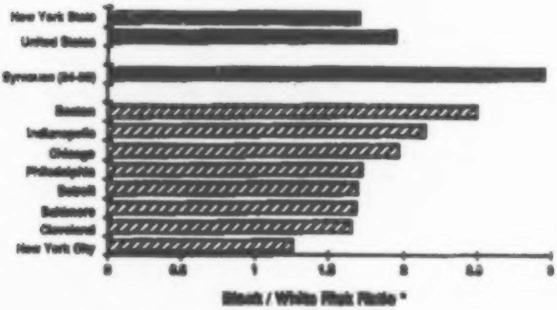


Notes

Data for other cities, New York State, and United States from The Maternal and Child Health Data Book. 1988. Children's Defense Fund.
Syracuse data from NYS Health Department Vital Records.
Analysis and graph by Bureau of Surveillance & Statistics,
Onondaga County Health Department.

Figure 30

Infant Mortality for Syracuse Relative to other Cities, 1985.
D. Relative Risk of Black Infant Mortality

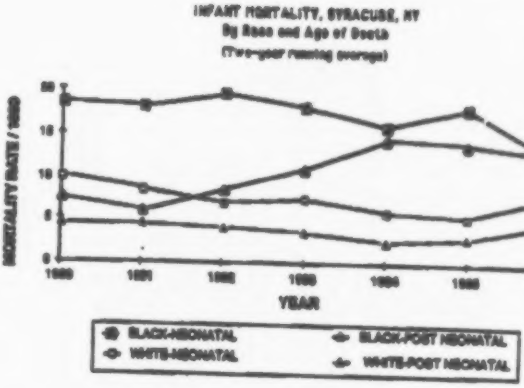


Notes:

* Risk Ratio = Black Infant Mortality / White Infant Mortality

Data for other cities, New York State, and United States from The Maternal and Child Health Data Book. 1988. Children's Defense Fund.
Syracuse data from NYS Health Department Vital Records.
Analysis and graph by Bureau of Surveillance & Statistics, Onondaga County Health Department.

Figure 4



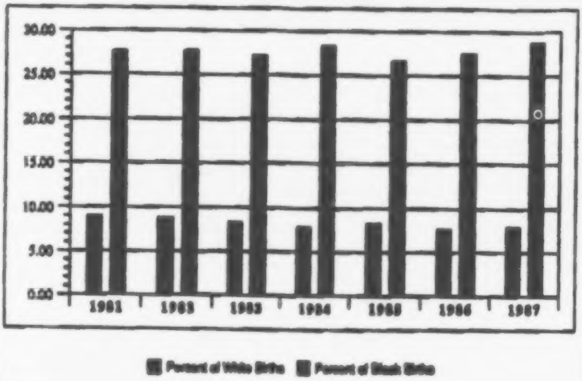
NOTES:

Running average calculated as average of the current year and the next year (e.g., 1985 data point is the average of 1985 and 1986).

Rates are uncorrected for mortality during the neonatal period.

Data from the NYS Health Department. Analysis and graph prepared by the Bureau of Surveillance and Statistics, Onondaga County Health Department.

Figure 5. Births to Teenage* Mothers by Race and Year
Onondaga County, NY 1981-1987

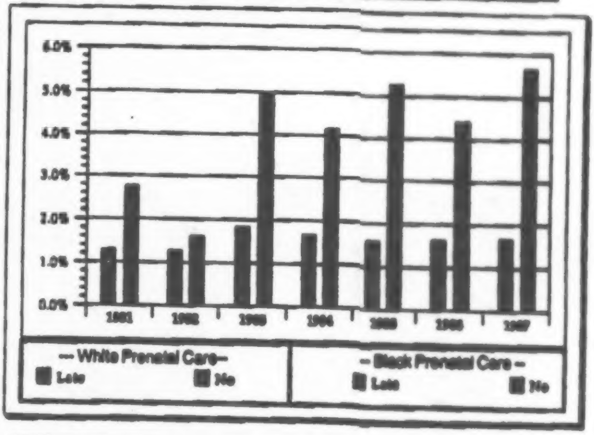


	— Race: WHITE —		— Race: BLACK —	
YEAR	Number	Percent	Number	Percent
1981	525	8.89 %	211	27.62 %
1982	511	8.74 %	226	27.70 %
1983	496	8.30 %	218	27.10 %
1984	476	7.76 %	232	28.26 %
1985	515	8.22 %	234	26.50 %
1986	464	7.42 %	251	27.46 %
1987	448	7.88 %	281	28.75 %

Data Source: New York State Vital Records
Analysis and Graph prepared by Onondaga County Health Department
Bureau of Surveillance and Statistics

* Births to females age 10 through 19

Figure 6 Entry to Prenatal Care by Race and Year
Onondaga County, NY 1981-1987

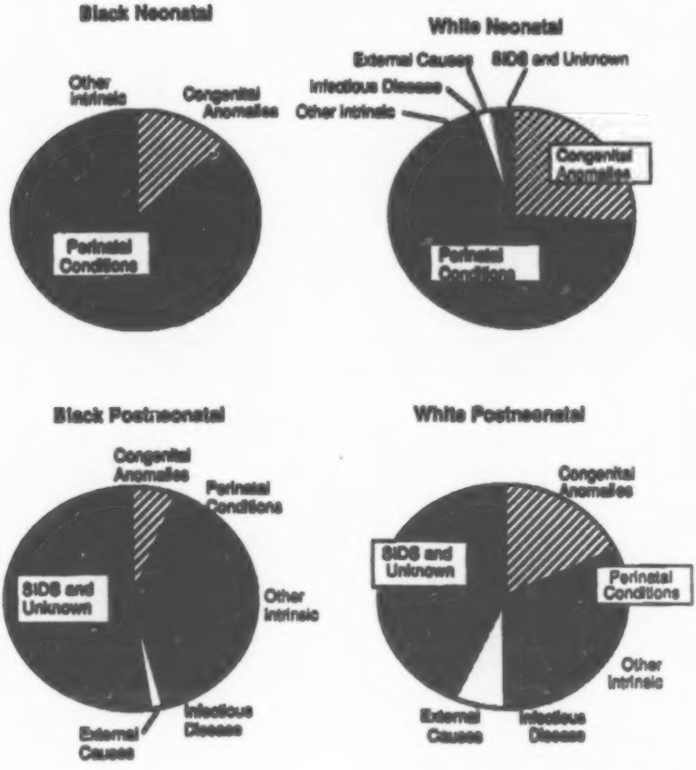


	—— Race WHITE —			— Race BLACK —		
YEAR	Late PNC	No PNC	Late/No	Late PNC	No PNC	Late/No
1981	0.9%	0.4%	1.3%	0.9%	1.9%	2.8%
1982	0.9%	0.3%	1.3%	1.1%	0.5%	1.6%
1983	1.5%	0.4%	1.8%	4.4%	0.6%	5.0%
1984	1.2%	0.5%	1.7%	3.4%	0.7%	4.1%
1985	1.1%	0.5%	1.6%	3.9%	1.4%	5.3%
1986	1.3%	0.4%	1.6%	2.8%	1.7%	4.4%
1987	1.2%	0.5%	1.7%	4.6%	1.0%	5.6%

Data Source: New York State Vital Records
Analysis and Graph prepared by Onondaga County Health Department
Bureau of Surveillance and Statistics

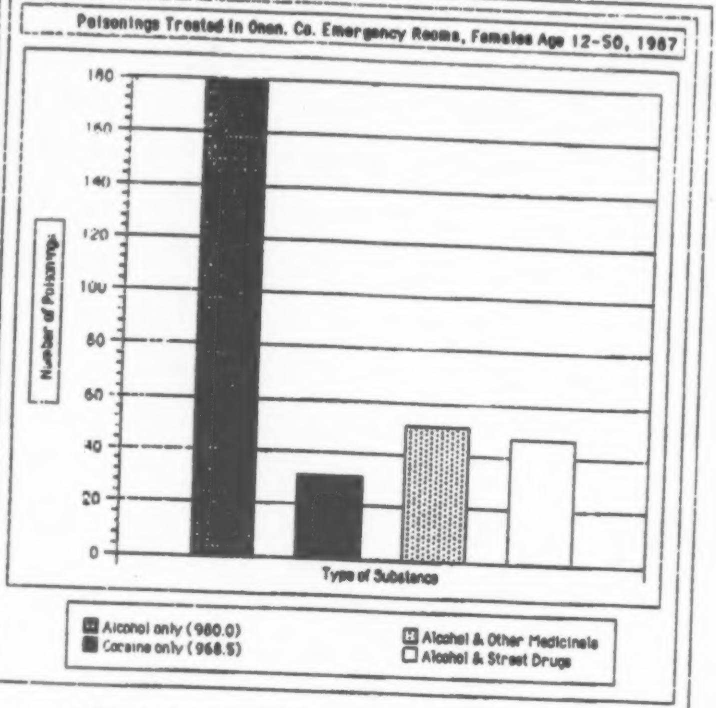
Figure 1

Causes of Infant Deaths Onondaga County Residents, 1981-1986



Prepared by Onondaga County Health Department
Bureau of Surveillance & Statistics

SEN



Poisonings Treated in Onon. Co. Emergency Rooms, Females Age 12-50, 1987

Emergency Room Poisonings, Age 12-50, Females

Cause of Poisoning	# of Poisonings
Alcohol only (980.0)	179
Cocaine only (968.5)	31
Alcohol & Other Medicinals	51
Alcohol & Street Drugs	47

Prepared by Onondaga County Health Department, Bureau of Surveillance & Statistics
Source: Emergency Room Poisoning Reports From Four Onondaga County Hospitals

Chairman **Miller**. Thank you very much, all of you, for your testimony. Again, I guess we get back to where we were with the previous panel, and that is that a number of different individuals coming from different directions have arrived at the same conclusion: there is a way to spend money within this system that makes sense, and there is a way to spend money within the system that doesn't seem to make a great deal of sense.

Some of how you spend it, I recognize, is mandated either by us or the state or local entities.

But let me start with you, Dr. Burton. In theory, when you get all done with your proposal, you've got to be accountable to a Board of Directors who say, "We're still in a profit-making business." You are here to make a profit.

And so you had to weigh this on a very strict cost-benefit ratio. We can talk about that in the abstract, and I honestly believe it. And I think I've seen it proven enough times over and over and over in different communities.

But you have, I assume, very strict guidelines. You're not a benevolent society. You care about your workforce. You care about keeping down these costs.

And, again, those policy considerations and fiscal considerations seem to merge at this point.

Dr. **Burton**. That's correct.

Chairman **Miller**. What did people say when you started on this effort? Did they believe that it would work or were they just outraged about the cost of medical care?

We hear more and more employers just about ready to pull their hair out on this one.

Dr. **Burton**. Well, they are concerned about, and we were concerned and continue to be concerned about, the cost of medical care.

But also we can look at strategies, and we look at return on investment. And if you look at return on investment for a prenatal program, you've heard a four to one return on investment for the federal government, $2 billion in costs, a possible investment of $500 million to decrease that cost or to alleviate that cost.

In each of our preventive health programs, our wellness health programs, we look at return on investment. And we have a good track record over the past eight years of meeting or exceeding a return on investment.

I think the literature is clear in the prenatal health care area that you can achieve those results.

Chairman **Miller**. Let me ask Dr. Eberly and Ms. Ruscitto. Both of you described your efforts at the local level to end duplication and conflicting goals and problems. And you decided to try it by consolidation.

And I think, essentially, Ms. Eberly, you did the same thing.

Ms. **Eberly**. Right.

Chairman **Miller**. You tried to consolidate this. But you said very specifically at the end of it, you had to break out all these costs for categorical purposes.

Ms. **Eberly**. That's right.

Chairman **Miller**. You had to attribute costs in one category to another to continue to receive your funding at your level——

Ms. **Eberly**. That's right.

Chairman **Miller** [continuing]. So you could apply it where you wanted.

Ms. **Eberly**. At the time I could devote all of my time to the program. We had an administrator, who was largely responsible for the budget. She retired three years ago and hasn't been replaced.

So I now have 23 budget columns as well as the programs and plans to go with those. So I can appreciate her frustration in our experiment.

But we truly did have one plan. I only wrote one plan a year, and we did have the coordinated staffing. And by the staff knowing the other programs—and, obviously, with a pregnant woman, it's important to get WIC.

It's important to then go into some kind of family planning so that you don't have repeat pregnancies, certainly in high risk situations.

And also many of these clients were Medicaid recipients and were eligible for the periodic screening and EPSDT. So we truly did do a good service for our clients.

Chairman **Miller**. Let me just stop you there for a second.

Ms. Ruscitto, the same problem with you?

Ms. **Ruscitto**. We're expecting we're going to have to still continue to report to the state sources in separate reporting systems, but we're going to ignore that at this point in time.

We just think we have no other choice other than to try to pull those programs together and run parallel systems, do what we have to do on a local level and report to the state what they need.

We're beginning to hear, though, I think, a little bit of a change in the environment at the state level. I've had a number of people, including a representative of the Governor's Office, say to me, "Lookit, we've got to do business differently. Come to us with a model. Let us put together the waivers for you. And let's see how we can make it work."

So our hope is that we're going to find some friends at other levels that are going to make this thing happen within our particular community.

Chairman **Miller**. Well, in fact, what you're describing, I think, and what Dr. Burton is describing is a patient-based system or a client-based system.

Ms. **Eberly**. What we ran into, you see, is the state and, I assume, the federal government. Certainly, when you have the funding for these programs coming from Welfare and from Agriculture, as well as Health, when you're organized that way at the state and federal levels, you don't recognize the other programs. You don't see the whole human being or the family. All you see is your program and what you want or the data you want.

Chairman **Miller**. And you're not going to get an argument from me on that. One of our concerns, though, has been that essentially most programs here—and we just went through a decade where the President was always sending us block grant proposals. He was going to block grant everything.

But we always found out that somehow in the transition from categorical to block grant, there was always a fee. And usually somewhere between 25 and 40 percent of the money disappeared in that process. And the theory was that there was 25 to 40 percent efficiency.

My problem, and I think a lot of other members of Congress' problem, was that they didn't recognize that there was also an unmet caseload. And so rather than taking the money away from those programs, that money could have been plowed back in to expanding the caseload on a more efficient basis. But somehow that was never pulled together.

I think you're quite correct. We're seeing rumblings now, where either governments are coming in and asking for waivers so that they can develop the kinds of programs that both of you have talked about, and/or local entities are essentially doing what you're doing, saying "I'll worry about the bureaucratic tail on this program later. Right now we're going to develop a program on a consolidated basis that meets the needs of the clients."

So I suspect that we're getting ready to make a shift here in one fashion or another, but I don't think the Congress will ever move toward block grants as long as there continues to be this huge extraction of funds in the process. Nobody believes that we're meeting the current need this morning, but at the same time recognizing, certainly, that that's the direction we probably should go in terms of simplifying the life of the patient, the client, and you.

So I think, you know, one of the things we hope to be able to take from this Committee as a demonstration to the committees of jurisdiction that write these laws is that there is another way to approach this.

And we've got to start operating on some good faith in terms of people's ability to meld money for the benefit of the clients in the system. And that's why you're here today.

Dr. Niles and Dr. Howse, let me ask you something. You heard this morning the goal of reaching, I think it was, 7 deaths per 1,000 births by the year 2000 as the national goal.

My concern is, as I look at these figures—and there's a reason I have not gone into this in depth in that we have had other hearings on that.

But, it's sort of like the World Series during the war years. There's an asterisk by those years because certain players weren't available or there's probably one here for the earthquake.

And we're going to start having an asterisk here, and we're going to talk about the drug years. The notion that if we couldn't meet the 1990 goal of the Surgeon General, the fact that we're going to meet and exceed that goal for the year 2000, given the overlay of drugs that we've seen since, essentially, 1983 and 1984, are we talking reality here?

I mean, if we continue on the same course, if you lay down drugs on top of this scene that we see in the District or anywhere else, is it conceivable?

Ms. Howse. I'll let Dr. Niles comment on the drug problem because I think he sees it firsthand every day.

But I think, quite frankly, that we're not going to make a dent in saving these 10,000 babies that have been talked about this morning until we're ready to go full bore in three ways.

Number one, we've got to beef up health education and do some changing of maternal and paternal behaviors early on. That has to do with, you know, don't smoke, don't drink, don't do drugs during pregnancy, and increasing the likelihood that women are going to seek prenatal care early.

Secondly, we've got to target the high risk populations. There are pockets of low birth weight and infant mortality in any community you visit in the country.

We've got to target those high risk areas and make sure that those women's prenatal and delivery costs are covered in some fashion.

And, secondly, we've got to case manage. And there have been a whole bunch of different ways that have been talked about. We've got to case manage those high risk pregnancies to reduce the likelihood of infant mortality and low birth weight as the outcomes.

Thirdly, we've got to make prenatal care more user friendly. Sarah Brown commented, I thought very clearly, about the perspective of the Institute of Medicine, which is you can get women all dressed up and ready to go to the clinic. And if the clinic is not ready for them, the barriers haven't been reduced, they're not going to come back again. And you've lost the battle right there.

So I think those three points all need to be converged upon in order to really make a serious dent in the problem. The drug issue is clearly important, and I'm sure Dr. Niles can comment on that one.

Dr. **Niles**. To answer your question, no, I don't think that the Surgeon General's guidelines will be met. I think that some of the things that have already been raised are very key. It's extremely difficult.

And I see in the District of Columbia, and I'll be honest with you, the level of frustration as to what exactly to do.

I think that what we have done, we have identified those census tracks in the District where the high rates of infant deaths are occurring.

We do need managed care programs. We do need the "Better Babies" projects, Resource Mothers in South Carolina, those types of programs. They employ people who would not otherwise be employable. So it's an advantage on both ends to get to these women to help them to get into care.

But it becomes an attitudinal thing. And I don't know how much education we can provide in some people's circumstances, the despair that's there that they use drugs.

They know they should not use drugs. They will sit in the office and cry and say, "I didn't mean to do it. I'm sorry. I won't do it again." You test the urine two office visits later, and they're positive for cocaine again.

How we address that attitudinal situation, that behavioral problem, whether it's jobs, whether it's economic change, I don't know the answer.

And I know there are middle class women who use drugs as well, so it's not just the poor women who are using drugs.

Chairman **Miller**. There is, I think, a fair amount of evidence, whether it's dealing with infant mortality or it's dealing with literacy or it's dealing with job training, education in a broad sense, that it's very difficult, and may be merging on the impossible, to pluck a person out of their environment for one doctor's visit or one hour of training or two hours of education or even a full day for a young child and put them back in that environment and believe that you're going to have any lasting impact. We're talking about some systemic problems within the community, that if they aren't addressed on a comprehensive basis, simply erode the progress you can make with your 30 office visits in a year or 10 minutes in an office visit.

Dr. NILES. It's a Band-Aid. There are a number of them. But there is a deeper societal situation that has to be addressed.

Why do the women who have repeated pregnancy losses continue to have repeated pregnancy losses? One of the risk factors, of course, is a previous loss. And they continue to have children.

Dr. Davidson mentioned about family planning. Why don't they come in for care? They say they won't take the pills because they make them sick, but that's not the reason.

They don't want to take the pill because the significant other doesn't want them to take birth control. Why doesn't he want them to take birth control? Because this proves his manhood by getting this woman pregnant.

There are so many deep issues that are extremely difficult. And all I think we can do is to try to hold on. And, as I said, in the District our rate was sort of steady, but with the drug thing, it's really gotten out of hand.

But we've got to continue to work at it. I think the managed care programs, the outreach efforts to try to get women in are extremely important.

Now, as I mentioned before, 50 percent of the deaths occur in babies under two pounds. And this has been our study, and I think it's been demonstrated nationally.

And we've got to get to those situations to get those women into care to try to prevent those babies from losing those babies early, but preventing those women from getting pregnant again.

Now, I know the gentleman mentioned the issue about someone raised about they should be sterilized. I don't think that's the answer, but I think there has to be something done to prevent these women from getting pregnant.

And whether it's attitudinal changes, whether we need to get the behavioral psychologists in here to try to help us address these issues because the gentleman mentioned throwing $500 million at the program again is not going to change, then people get refractory.

Then even the good programs that are helping, holding us on, because it would skyrocket if we didn't have programs, those would be the ones withdrawn because, say, hey, look, this thing is not working; the rate is not going down.

But also the rate is not going up as high or as fast if these programs were not in place.

Chairman MILLER. My view of political history is that we have gone through that phase. We went through that phase in 1981 when we decided that nothing worked and, therefore, we threw everything out.

And what the Select Committee has been about to some extent, I think, with a great deal of success, is working our way back through that process to look at programs that, in fact, did work.

We identified a set of programs where good economics, good budgetary policy, and social policy merged.

We've identified a number of those. One of those has obviously been a number of programs around maternal and child health and prenatal care.

The reason you were picked as witnesses is because, again, my sense of political history tells me that we are very rapidly accelerating toward agreement about the need, the urgency, and the necessity to deal with the problems of prenatal care, and the care of children, let's say, up to six years of age.

On a bipartisan basis, the Administration, Congress, we now recognize it. It's been drilled into us enough that we accept the testimony. We accept the evidence.

The question will be whether we will be able to have a road map to lead us through how to do that the best way we can.

And that's really what this hearing has been about—to look at some local efforts, to look at those problems, and then to turn around to our colleagues on the legislative committees and say to them that before we now ask policy-makers to put in additional dollars, and there's agreement we should put in additional dollars, we've got to devise a system that is better than it is today, for those of you who are delivering care at the local level.

And, as we found out this morning, that's a wide range of problems, but some of them aren't terribly difficult should we decide that we want to address them.

The federal government can affect the outcome of some of those policies in terms of the efficiencies of the dollars and the coordination and the consolidation of these efforts and make it client-directed.

Whether we can erase all the environmental concerns in one fell swoop around this issue of prenatal care, I don't think we can.

But we've got to recognize them and maybe intensify the effort with respect to those clients in those areas and recognize that they're going to be much more difficult to get engaged in this service than will other people who don't suffer all of those other environmental problems.

But I really think we're at a point where the politics are almost nonexistent in terms of recognizing the need.

Six, seven, eight years ago a lot of people said this really wasn't a problem. I think everybody now recognizes it's an extraction of the deficit.

Its call on dollars from this government and the public sector and the private sector are huge. And something needs to be done.

And I just want to thank you all very much for your time and your testimony. One of the functions of this committee is to take these findings and this testimony.

And everybody here is on a committee of jurisdiction that will legislate in these fields and see whether we can put it together.

And so far the evidence has been that in both the Ways and Means Committee and the Commerce Committee, dealing with Medicare and Medicaid, we've been able to join Republicans and Democrats around these issues.

But, obviously, some refinement has to take place so that we can increase the confidence of members as they vote for those additional dollars.

This has been very, very helpful to us in that quest, and I want to thank you very much for your time and your testimony.

With that, the Committee will stand adjourned.

Let me say that Congressman Walsh wanted to be here until the vote, but he's on the floor. And he asked if he might submit some questions for the record.

So we may be forwarding to you some written questions and ask you if you might respond. It would help us out.

Thank you.

[Whereupon, at 12:47 p.m., the Committee was adjourned.]

[Material submitted for inclusion in the record follows:]

ONE HUNDRED FIRST CONGRESS

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U.S. House of Representatives

SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 HOUSE OFFICE BUILDING ANNEX 2
WASHINGTON, DC 20515

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TELEPHONE 226-7692

November 15, 1989

Ezra Davidson, Jr., M.D.
The King-Drew Medical Center
12021 South Wilmington Avenue
Los Angeles, California 90059

Dear Dr. Davidson:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Caring for New Mothers: Pressing Problems, New Solutions," on October 24, 1989. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by November 22 with any necessary corrections.

In addition, Representative Thomas J. Bliley, Jr., has requested that you respond in writing to the following questions so that they may be included in the hearing record:

1. On the very first page of your testimony, you make a very critical point: "Expanding Medicaid alone, adding home visiting alone, increasing reimbursement alone, nothing alone will solve the problems. There must be major, fundamental change in the ways we finance and deliver care for low-income women." You also state on page 8 that program administration needs to be "user friendly" and that "continuing to incrementally expand eligibility and coverage, even with increased reimbursement, is clearly not enough." Would you support the consolidation of categorical programs which serve women in order to ensure that programs are properly planned and coordinated?

2. The most important item that we found in our survey is that most of the publicly supported maternal health agencies do not provide prenatal care. Should we place more of an emphasis on funding only those providers which offer prenatal care?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

Enclosure

The
American
College of
Obstetricians and
Gynecologists

Office of President Elect
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December 13, 1989

The Honorable George Miller
Chairman, Select Committee on
Children, Youth, and Families
U.S. House of Representatives
385 House Office Building Annex 2
Washington, DC 20515

Dear Mr. Miller:

I was pleased to be invited to appear and testify before the Select Committee on Children, Youth, and Families at the hearing, "Caring for New Mothers: Pressing Problems, New Solutions," on October 24, 1989.

I am forwarding, as requested, answers to the two questions of Representative Thomas J. Bliley, Jr, for the hearing record as stated in your letter of November 15, 1989.

1. Yes, I would support the consolidation of programs which serve women in order to ensure that they are properly planned and coordinated. I would want to be assured, however, that the comprehensive range of services would be mandated, especially family planning services, and that access would be simple and straightforward from both an administrative and location point of view.
2. Yes, I think you should place more emphasis on funding publicly supported maternal health agencies that provide prenatal care. I would emphasize that the care should be given according to standards provided by ACOG or the PHS expert panel on the content of prenatal care.

Sincerely,

Ezra C. Davidson, Jr MD.

Ezra C. Davidson, Jr, FACOG
President Elect

ECD:fmw

ONE HUNDRED FIRST CONGRESS

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U.S. House of Representatives

SELECT COMMITTEE ON
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TELEPHONE 226-7692

November 15, 1989

The Honorable James O. Mason, M.D.
Assistant Secretary, Public Health Service
Department of Health and Human Services
200 Independence Avenue, S.W., Room 716-G
Washington, DC 20201

Dear Dr. Mason:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Caring for New Mothers: Pressing Problems, New Solutions," on October 24, 1989. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by November 22 with any necessary corrections.

In addition, Representative Thomas J. Bliley, Jr. and I are requesting that you respond in writing to the following questions so that they may be included in the hearing record:

QUESTIONS FROM REPRESENTATIVE BLILEY

1. To what extent is the fragmented service system itself to blame as a barrier to comprehensive services?

2. Would you support administrative consolidation of categorical programs if the states and local governments would agree to deliver all necessary services in an integrated system?

3. As a former state health director, do you think the states are capable of meeting their administrative responsibilities without all of the federal oversight that goes with categorical programs?

4. Drug abuse among pregnant women appears to threaten the progress we have made in reducing the infant mortality rate. Could you provide us with a breakdown of the programs which are being funded specifically target pregnant women in drug abuse prevention and treatment?

QUESTIONS FROM REPRESENTATIVE MILLER

The Administration's Plan to Reduce Infant Mortality

We share your deep concern for children and your commitment to reducing infant mortality and we stand ready to assist you in your efforts. During the Presidential campaign, the President made promises to improve the health of the nation's children and to reduce infant mortality, specifically:

** 1) mandatory Medicaid coverage for all children with family incomes below 100% of poverty;

** 2) phased-in affordable coverage for pregnant women and infants up to 185% of poverty and to older children through a subsidized premium or a Medicaid "wrap-around" to employer coverage for dependents;

** 3) expanded MCH Block Grant to provide extensive health education and information about Medicaid and availability of community prenatal services directed to pregnant women and case management for high-risk pregnancies;

** 4) "Sufficient" funding for WIC.

To date, the President has supported an expansion of Medicaid to pregnant women and infants in families up to 130% of poverty.

1. What is the President's plan is to improve child health and reduce infant mortality? Is there a plan to implement any of the above strategies promised during the campaign?

2. We are in a crisis situation. The low birthweight rate actually increased in 1987, infant mortality is rising in major cities, and substance abuse is making an already difficult situation worse. I understand there is still more we have to learn, but as you testified we have the knowledge currently to save 10,000 of the 40,000 infants who die each year. What are the Administration's immediate plans to deal with these crises? How soon will they be implemented?

3. I understand the President announced the formation of a Presidential Task Force on Infant Mortality last summer. What has the Task Force accomplished so far? What are the Task Force's recommendations to the President? When does he plan to implement them?

4. Several prestigious panels, including the Institute of Medicine, have studied and documented the barriers -- financial and otherwise -- to early prenatal care. There is no longer any dispute as to the significance of these barriers. Each year, there are still over 1 million women who receive inadequate care and this has not changed over the last

8 years. What are the Administration's plans to overcome the barriers that prevent so many women from getting care and when will they be implemented?

Surgeon General's Goals for the Year 2000

At this point in time, given the dramatic slowdown in the improvement of the infant mortality rate during this decade, we have no hope of reaching the Surgeon General's goals for reducing infant mortality by 1990.

1. When will your agency have a plan to reach the Surgeon General's new goals to reduce infant mortality and improve child health for the Year 2000? What do you expect the plan to include?

2. Are you prepared to make commitments to reach those goals by the beginning of the new century?

Administration's Stand on Medicaid Expansions

1. What is the Administration's position on the legislation pending in the House Budget Reconciliation bill right now that would phase-in mandated Medicaid expansions to pregnant women and infants who live in families earning up to 185% of poverty?

2. If the Administration is now opposed to more mandates, are you prepared to make commitments to support serious incentives to states that have not yet, and probably won't, pick up the current options to extend Medicaid? If yes, what type of incentives?

Integrated MCH Services and Administration's position on MCH Block Grant expansion

I understand you have a long-standing interest in the concept of "one-stop shopping."

1. Can you elaborate on what you mean by "one-stop shopping?" What efforts is your agency engaged in to encourage such services?

2. What are you doing now to enhance interagency cooperation and coordination between Medicaid, MCH, WIC and other relevant agencies at the Federal Level? How do you plan to encourage and improve coordination at the state and local level? What is the federal role?

3. Have you ever considered reintroducing support for the very effective, "one-stop shopping" Maternal and Infant Care Clinics (MIC's) which were more prevalent before the block grant took effect in 1981? Why or why not?

As you know, there is also legislation pending that would increase the Maternal and Child Health Block Grant's authorization by $100 million and use some of these funds for an infant mortality initiative, including funds to initiate more "one-stop shopping" services.

1. Does the Administration support this legislation? Why or why not?

Provider Shortage

Given the current crisis in the shortage of obstetricians willing or able to provide prenatal care and delivery services to low-income women, what does the Administration plan to do to both improve private physician participation and expand and strengthen the public health infrastructure in this country so that services are available to everyone who needs them? When do you plan to do this?

Family Planning

A significant finding of the Expert Panel on the Content of Prenatal Care was that preconceptional services, such as family planning, should be considered in any strategy to improve infant health.

1. What are you going to do to improve access to family planning services within your agency, especially for the hardest to reach groups?

2. Given your commitment to improving integration of maternal and child health services, and this major finding of the Expert Panel, how would you assure follow-up services for reproductive health care after a woman gives birth, especially if she loses her Medicaid coverage soon after the birth of her child? What will you do to make sure she can still get services? How will one-stop shopping help her if she doesn't have any way to pay for services?

Substance Abuse

Substance abuse is contributing to an already chaotic system of health care delivery for pregnant women, especially in large urban settings, and seriously affecting the health of newborns.

Congress appropriated money in the drug bill to the Alcohol Drug Abuse and Mental Health Administration to prevent and treat substance abuse among pregnant women.

1. Given the important role maternal and child health must play, and your agency's expertise in serving pregnant women, how and when do you plan to coordinate with ADAMHA to implement these programs?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

Enclosure

RESPONSE TO QUESTIONS POSED BY CONGRESSMAN THOMAS J. BLILEY, JR.

Q. To what extent is the fragmented service system itself to blame as a barrier to comprehensive services?

A. The complex and fragmented nature of the health system can pose a barrier to pregnant women, who may not know the services for which they are eligible and how to go about obtaining them. For that reason, as I noted in my testimony, we are looking hard at one-stop shopping projects which seek to co-locate health and social services and allow a woman to establish eligibility for Medicaid and other services at the same time and at the same location she is receiving health care.

Q. Would you support administrative consolidation of categorical programs if states and local governments would agree to deliver all necessary services in an integrated setting?

A. We think it is helpful when all needed services are available in one location. Through one-stop shopping projects, we hope to demonstrate that existing programs can be made easier and more convenient to use. These projects would co-locate health and social services at a single site.

Q. As a former state health director, do you think the states are capable of meeting their administrative responsibilities without all of the federal oversight that goes with categorical programs?

A. Having worked both as director of the Utah Department of Health and at the Federal level as director of the Centers for Disease Control, a PHS agency that as you know works closely with the State health Departments, I can see benefits to both approaches. I think there might be an approach that allows states the freedom to make their own resource allocation decisions while giving them the benefit of technical assistance from the Federal Government. Certainly as the Assistant Secretary for Health, I have come to appreciate the necessity of data collection from state programs to monitor our national goals of reducing low birth weight babies and infant mortality.

Q. Drug abuse among pregnant women appears to threaten the progress we have made in reducing the infant mortality rate.

Could you provide us with a breakdown of the programs which are being funded which specifically target pregnant women in drug abuse prevention and treatment?

A. Several initiatives come to mind.

- The National Institute on Drug Abuse has designated research on the developmental effects of abused drugs as one of its top priorities. In November 1988, they issued a program announcement soliciting applications for the study of maternal and paternal drug abuse and its effects on the offspring. That program is being expanded this year.
- As a part of the President's National Drug Control Strategy, additional support will be provided for ADAMHA's Pregnant and Post Partum Women and their Infants Demonstration Grant Program.
- Also as part of the National Strategy, ADAMHA will expand existing and develop new areas of clinical research focused on cocaine, maternal and fetal effects, AIDS, and other infections.
- Finally, additional anti-drug media outreach activities that emphasize the dangers of using illegal drugs generally and "crack" in particular, and of using drugs during pregnancy will be undertaken.

RESPONSE TO QUESTIONS POSED BY CHAIRMAN GEORGE MILLER

The Administration's Plan to Reduce Infant Mortality

Q. During the Presidential campaign, the President made promises to improve the health of the nation's children and to reduce infant mortality, specifically:

1) mandatory Medicaid coverage for all children with family incomes below 100 percent of poverty;
2) phased-in affordable coverage for pregnant women and infants up to 185 percent of poverty and to older children through a subsidized premium or a Medicaid "wrap-around" to employer coverage for dependents;
3) expanded MCH Block Grant;
4) "sufficient" funding for WIC

What is the President's plan to improve child health and reduce infant mortality? Is there a plan to implement any of these strategies promised during the campaign?

A. Recent expansions of Medicaid have increased the number of pregnant women eligible for services. Effective April 1, 1990, the 1989 Title XIX amendments call for mandatory coverage of pregnant women and children under age 6 at income levels up to 133 percent of the Federal poverty income level. States have the option of extending coverage to pregnant women and infants at income levels up to 185 percent of the Federal poverty level, and to date, 12 States have fully implemented this option.

The recently enacted amendments to Title V of the Social Security Act, the legislation governing the Maternal and Child Health Block Grant, emphasize the importance of targeting resources to the problem of infant mortality by establishing five new focused grant categories, requiring linkage between State programs and the Year 2000 Public Health Service Objectives, the development of a model application form, new data collection and analysis requirements and the establishment of rural and outreach programs. The Administration has begun plans for the implementation of these changes.

The WIC program is under the jurisdiction of the Department of Agriculture and thus not within this Department's jurisdiction. We do note, however, that in reauthorising the WIC program, WIC eligibility was made adjunct to Aid For Families with Dependent Children, Food Stamps and Medicaid. This will speed access to the WIC program for some women who may lack adequate nutrition during pregnancy.

Q. We are in a crisis situation. The low birthweight rate actually increased in 1987; infant mortality is rising in major cities and substance abuse is making an already difficult situation worse. What are the Administration's immediate plans to deal with these crises? How soon will they be implemented?

A. In essence this answer is similar to the preceding one. We must reduce the barriers, financial and otherwise, that pregnant women encounter in receiving prenatal care. I've noted the Department's immediate plans to implement the expanded Medicaid eligibility provisions recently enacted, and to implement the legislative changes made to the Maternal and Child Health Block grant, some of which will result in efforts targeted to areas where the need is urgent. I've also mentioned several of our efforts aimed at substance abuse.

But it is important to remember that there is still a great deal we do not know about the biological and behavioral causes of infant mortality and low birthweight. That is why we must continue to support a strong program of basic and applied research. Solving the problem of infant mortality is a longterm endeavor and new knowledge is a necessary tool.

Q. I understand the Administration formed a Task Force on Infant Mortality last summer. What has the Task Force accomplished so far? What are the Task Force's recommendations to the President? When does he plan to implement them?

A. Last summer, an interdepartmental task force addressing infant mortality was established at the request of the Domestic Policy Council's Working Group on Health Policy. The task force was charged with assessing the nature of the U.S. infant mortality problem and reporting to the Working Group on options that would reduce infant mortality and improve maternal and child health. The report of the task force has not yet been finalized.

Q. Several panels, including the Institute of Medicine, have studied and documented the barriers, financial and otherwise, to early prenatal care. What are the Administration's plans to overcome the barriers that prevent so many women from getting care and when will they be implemented?

A. Recent expansions of Medicaid have increased the number of pregnant women eligible for services. Effective April 1, 1990, the 1989 Title XIX amendments call for mandatory coverage of pregnant women and children under age 6 at income levels up to 133 percent of the Federal poverty income level. This will result in more women being eligible for prenatal care services.

But, financial barriers are not the only impediments for pregnant women's receipt of health care. Some women are not aware of the services which are available; others are not convinced of the benefits of prenatal care. Services may be inconveniently located or require long waits for appointments.

That is why the Public Health Service is actively looking into "one-stop" shopping, through pilot projects this Fiscal Year. One is located at the Central Virginia Community Health Center, New Canton, Virginia; the other is based at the Alabama Department of Health. The results of these projects, in conjunction with information we are gathering from the activities of several States will help guide us in the further implementation of this concept.

Current activities of the Health Resources and Services Administration, in particular through the Office of Maternal and Child Health and the Community and Migrant Health Centers, and the Centers for Disease Control also provide many examples of ways we are addressing the barriers many women face in receiving care.

Also, the Health Care Financing Administration and the Office of Maternal and Child Health have jointly sponsored a project with the American College of Obstetricians and Gynecologists aimed at promoting increased provider participation in publicly funded perinatal service programs.

Goals for the Year 2000

Q. When will your agency have a plan to reach the Surgeon General's goals to reduce infant mortality and improve child health for the year 2000? What do you expect the plan to include?

A. The plan for the year 2000 will be published as a report of the Public Health Service, rather than as a Surgeon General's Report. We plan to publish this report in July 1990. Meanwhile, a draft of the report has received broad public review and comment between September and November 1989. The priority on maternal and child health proposes new infant mortality objectives, with a target of 7 infant deaths per 1,000 live births by 2000 for the population as a whole, and different targets representing more challenging reductions for minority populations that are at higher risk.

In addition, there are 53 measurable objectives relating to child health, arrayed across the 21 priority areas that are proposed for the year 2000 plan. A strong recommendation from the public review and comment period is to add a priority area on child health; that recommendation is currently under serious consideration within the Public Health Service.

Q. Are you prepared to make commitments to reach those goals by the beginning of the new century?

A. The Federal role in achieving a set of national objectives is one of shared responsibility for achievement, not total ownership. The goals and objectives set for 2000, like those set for 1990, are developed through a national process, involving State and local health agencies, voluntary and professional associations, and many private professionals and consumers of health care. The Federal government, by taking the leadership in crafting this plan, commits itself to playing a significant role in achieving the targets that are contained in the plan, but it will only be able to do so in partnership with the other critical public and private sectors. The goals and objectives that are being set are both realistic and challenging, and they can be achieved, given commitment of all relevant resources.

Administration's Stand on Medicaid Expansions

Q. What is the Administration's position on the legislation pending in the House Budget Reconciliation bill that would phase in mandated Medicaid expansions to pregnant women and infants who live in families earning up to 185 percent of poverty?

A. Recent passage of the OBRA 89 legislation provides for coverage of pregnant women and children under age 6 up to 133 percent of the Federal poverty level by April 1, 1990. (The Administration had proposed coverage of up to 130 percent of poverty.) This increase begins to address the need for services among this high-risk population and does not prevent States from exercising their option to include pregnant women and infants up to 185 percent of poverty if they possess the means and resources to do so.

To date, 12 States have fully implemented this option; three States have implemented up to 150 percent; and two States have implemented up to 125 percent.

Q. If the Administration is now opposed to further mandates, are you prepared to make commitments to support serious incentives to States that have not yet, and probably won't, pick up the current options to extend Medicaid? If yes, what type of incentives?

A. The Administration has agreed to a request by the National Governor's Association to postpone proposing any further mandates until such time as States have an opportunity to review their respective fiscal positions.

The Health Care Financing Administration's (HCFA's) Maternal and Infant Initiative coordinates several facets of Federal health assistance in order to facilitate better care. The initiative is directed by a Steering Committee including all HCFA Associate Administrators and oversees a Task Force of HCFA, PHS, WIC and Regional Representatives. The initiative's objectives include:

- coordinating procedures and efforts of Medicaid, PHS, Maternal and Child Health State Offices, and WIC programs on State levels;

- encouraging full implementation of Medicaid eligibility and coverage for pregnant women and children;

- encouraging States to conduct outreach efforts to those at high risk;

- increasing provider participation; and,
- encouraging use of targeted case management and special waiver authorities to serve this group.

The MIH Task Force has conducted workshops to exchange information, to implement MIH initiatives in States, and to form detailed regional and State plans.

Visits to States have been made to assist in making maximum use of available Federal resources to support their efforts directed at infant mortality.

Integrated MCH Services and Administration's Position on MCH Block Grant Expansion

Q. Can you elaborate on what you mean by "one-stop shopping?" What efforts is your agency engaged in to encourage such services?

A. By "one-stop shopping" we mean the co-location or integration of a variety of health and social services in order to make these services more convenient for the client. The term has become the focus of great public attention and debate in recent months mainly as a result of the work of the National Commission to Prevent Infant Mortality. The National Commission identified the difficulty that many women have in gaining access to quality prenatal care as a major problem of our nation's health care system and proposed the concept and practice of one-stop shopping as a possible solution to part of the access problem.

We have already begun to implement one-stop shopping demonstration projects in various sites throughout the country. Included among these are the following pilot projects.

At the Central Virginia Community Health Center in New Canton, Virginia, seven rural counties are developing on-site Medicaid and WIC enrollment and improving record transfers among clinics and hospitals. In another pilot project, the Alabama Department of Health is working with its Human Resources, Mental health and Medicaid agencies to integrate financial eligibility requirements. There are also several State projects which we are studying closely as well as a national advisory committee which will help us determine the best practices for one-stop shopping.

Q. What are you doing now to enhance interagency cooperation and coordination between Medicaid, MCH, WIC and other relevant agencies at the Federal level? How do you plan to encourage and improve coordination at the State and local level? What is the Federal role?

A. Interagency coordination among Federal agencies such as those you mentioned has been a priority concern that has continued to receive increased attention in recent years. We fully recognize that it is ultimately at the local level where these programs must come together and direct resources and provide services to individual clients with very different needs.

Our responsibilities at the Federal level are several: to develop and disseminate improved research, methods and practices; to test various approaches to service delivery; to assure that limited resources continue to be used as effectively and efficiently as possible; to remove cultural, financial and social barriers to participation; and to provide more and more accurate health information to both consumers and providers.

During the past year a task force comprised of Health Care Financing Administration (HCFA) and Public Health Service representatives has met to ensure full implementation of Medicaid requirements for serving pregnant women and infants. This Task Force works with HCFA's Maternal and Infant Health Initiative to ensure that programs address the infant mortality problem to the fullest extent possible. Jointly sponsored regional meetings with State representatives are now underway.

The Office of Maternal and Child Health provides support to an ongoing Medicaid technical advisory group which identifies and discusses issues of coordination at the Federal, State and local level between the Medicaid and Title V (Maternal and Child Health) programs. Currently under review are State use of EPSDT data and data matches between MCH, Medicaid and vital statistics records.

Coordination has also taken place over the past few years with the Department of Agriculture and its nutrition and health-related programs. The Office of Maternal and Child Health and other offices in the public health service have maintained both formal and informal relationships to improve nutrition, share research findings, promote breastfeeding and develop and disseminate public information.

All of these Federal programs also work with State, local and private organizations which have related missions. Through the National Governors' Association, for example, the OMCH is providing assistance to States concerning implementation of the expanded Medicaid options now available and the integration of these alternatives with relevant State programs.

Meetings, conferences, joint publications and seminars have also taken place between one or more of these Federal agencies and private foundations such as the Kaiser Foundation, the Robert Wood Johnson Foundation, the Washington Business Group on Health and the Association of Maternal and Child Health Programs, as well as most major national and international professional associations, all with the general purpose of improving program coordination and cooperation.

Q. Have you ever considered reintroducing support for the very effective "one-stop shopping" Maternal and Infant Care Clinics (MICs) which were more prevalent before the block grant took effect in 1981. Why or why not?

A. There was nothing in the 1981 block grant legislation that prevented States from continuing support for Maternal and Infant Care (MIC) projects, as well as similar models of comprehensive services for pregnant women and infants, after the implementation of the legislation. Many States did, in fact, do just that, although under a variety of names other than the older MIC label.

States continue to have the flexibility to fund projects like the MICs through enhanced Medicaid services now available as a result of recent changes enacted in that legislation.

Q. As you know, there is also legislation pending that would increase the Maternal and Child Health Block Grant's authorization by $100 million and use some of these funds for an infant mortality initiative, including funds to initiate more "one-stop shopping" services.

Does the Administration support this legislation? Why or why not?

A. A series of amendments to Title V of the Social Security Act was recently passed by the Congress. Among the amendments is a renewed emphasis on efforts to reduce the nation's unacceptably high rate of infant mortality through a variety of approaches.

Included among these are: five new discretionary grant categories; a connection between State programs and the Year 2000 Public Health Service Objectives; interagency coordination; simplified access to providers through toll-free numbers; limits on administrative expenditures; common application requirement; payment of National Health Service Corps personnel with State Title V funds; special emphasis on data collection and analysis; and the establishment of special rural and outreach programs. The Administration has already begun to plan for the timely implementation of these legislative changes.

One-stop shopping, while not receiving a separate, categorical authorization in the new legislation, may still figure into demonstration plans at the State and local levels. Additional Federal demonstration projects may be supported assuming sufficient funds are appropriate.

Provider Shortage

Q. Given the current crisis in the shortage of obstetricians willing or able to provide prenatal care and delivery service to low-income women, what does the Administration plan to do to both improve private physician participation and expand and strengthen the public health infrastructure in this country so that services are available to everyone who needs them? When do you plan to do this?

A. The shortage of obstetricians, due in part to the crisis in the malpractice insurance industry, has not gone unnoticed by the Administration. Various agencies within the Department of Health and Human Services and in other Departments and independent agencies, in cooperation with the insurance industry, private foundations and professional associations, have dedicated significant resources to the study of this problem.

Most recently, this topic has also attracted the attention of representatives of various organizations who participated on the Institute of Medicine's Committee to Study Medical Professional Liability and the Delivery of Obstetrical Care. The Committee's report, which recognizes the shortage of obstetrical care, especially for low income women, includes recommendations for alternatives to the current tort system, funding of projects to seek solutions to the problem, a national database on malpractice claims and study of technological advances in obstetrical practice.

Also, the Health Care Financing Administration (HCFA) and the Office of Maternal and Child Health (OMCH) have jointly sponsored a project with the American College of Obstetricians and Gynecologists (ACOG) aimed at promoting increased provider participation in publicly funded perinatal service programs. Guidance on provider issues for both obstetricians and Medicaid programs will be developed in this project, as well as efforts to encourage medical students and residents in obstetrics/gynecology to consider careers in public health.

Family Planning

Q. What are you going to do to improve access to family planning services within your agency, especially for the hardest to reach groups?

A. The Public Health Service provides family planning care for about 4 million women annually under the authority of Title X of the Public Health Service Act. Eighty-five percent of these women are low income; one third are adolescents; and two thirds are younger than 25 years of age. In order to further reduce barriers to care, the Department of Health and Human Services has proposed that the Title X program be reauthorized as a State-administered program.

Such a State-administered program would promote broader access to family planning services by allowing for State and local input into decisions about where family planning services should be located and how services should be offered. A state-administered program would also allow for better integration of family planning services with other health care services provided by State and local health agencies, such as the maternal and child health services supported under the authority of Title V of the Social Security Act.

Q. Given your commitment to improving integration of maternal and child health services, how would you assure follow-up services for reproductive health care after a woman gives birth, especially if she loses Medicaid coverage soon after the birth of her child? What will you do to make sure she can still get services?

A. A State-administered family planning program will, by dint of its suitability for integration with other services, tend to reduce the number of women who suffer gaps in service in the post-natal period. Even if a woman should lose her Medicaid eligibility after the birth of a child, she would still probably be eligible for subsidized care under Title X which provides for free family planning services for low-income persons, and requires that charges be adjusted according to a sliding fee scale for persons with somewhat higher incomes.

Perhaps the largest obstacle which prevents the continuation of family planning care is widespread ignorance of the fact that family planning services are still needed and available for women who are sexually active in the post-natal period. Fortunately, informing women of the need for post-natal contraception is now a routine part of the hospital discharge process for most obstetric patients. Implementation of the Department's proposal for a State-administered family planning program will help to ensure that women receiving prenatal care or well baby care from maternal and child health programs managed by State and local health agencies are provided on-site information about family planning as well.

Substance Abuse

Q. Substance abuse is contributing to an already chaotic system of health care delivery for pregnant women, especially in large urban settings, and seriously affecting the health of newborns. Congress appropriated money in the drug bill to the Alcohol, Drug Abuse, and Mental Health Administration to prevent and treat substance abuse among pregnant women.

Given the important role maternal and child health must play, and your agency's expertise in serving pregnant women, how and when do you plan to coordinate with ADAMHA to implement these programs?

A. Associated with the current drug crisis is a new phenomenon of large numbers of drug abusing pregnant women. More attention must be paid to determining the extent of the problem in women, the impact on their children, and to the development and delivery of safe and effective treatments. The Public Health Service (PHS) agencies address this need in three broad, interrelated areas: (1) Knowledge Development; (2) Development of Outreach and Treatment Models; and (3) Enhanced Treatment Capacity.

Monies appropriated by Congress will support the following ADAMHA efforts in FY 1990:

ADAMHA will provide an additional $51 million for the treatment of substance abusing pregnant and postpartum women and their infants through demonstration projects funded by the Office for Substance Abuse Prevention (OSAP) Model Projects for Pregnant and Post-Partum Women and Their Infants Program and by NIDA demonstrations.

Also, some portion of the $135 million preliminary budget for ADAMHA's newly created Office of Treatment Improvement (OTI) will fund additional services to pregnant and post-partum women and their infants.

In addition, $24 million will be provided for research to be supported by ADAMHA's National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute on Drug Abuse (NIDA) Treatment research programs. These programs will examine the extent and potential consequences of maternal drug abuse on offspring; develop improved ways to enroll and retain drug abusing pregnant and post-partum women in treatment; and evaluate and develop improved treatment methods for substance abusing pregnant and post-partum women and their infants.

In addition to the above activities, ADAMHA addresses the needs of this population through a variety of broadly focused programs such as the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant, including its mandated Set-Aside for Women.

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U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 House Office Building Annex 2
Washington, DC 20515

[illegible]

November 15, 1989

Ms. Sarah S. Brown
3503 Quebec Street, N.W.
Washington, DC 20016

Dear Ms. Brown:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Caring for New Mothers: Pressing Problems, New Solutions," on October 24, 1989. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by November 22 with any necessary corrections.

In addition, Representative Thomas J. Bliley, Jr., has requested that you respond in writing to the following questions so that they may be included in the hearing record:

1. In an article earlier this year, you wrote:

   "Poor rates of participation in prenatal care reveal that the American maternity care system is fundamentally flawed, fragmented and overly complex...."

   "Although a new [maternity care] system might build upon existing arrangements, long-term solutions require fundamental reforms, not incremental changes in current programs."

   Would you consider the consolidation of categorical programs as part of this needed reform?

2. Should we consider funding only those programs which provide parental care as part of an integrated setting?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

Enclosure

DEC 21 1989

NATIONAL FORUM
ON THE FUTURE OF
Children
AND
Families

December 15, 1989

Honorable George Miller
Chairman
Select Committee on Children,
  Youth and Families
385 House Office Building Annex 2
Washington, D.C. 20515

Dear Honorable Miller:

Thank you for passing on the additional questions of Congressman Bliley.

I respond as follows:

1. In theory, the consolidation of programs helps to reduce the fragmentation. I allude to in the article you quoted. However, past history teaches that consolidation is often accompanied by net funding reductions--a prospect which is chilling, given the growing need for well-financed human services. Funding, of course, needn't necessarily decrease if programs are drawn together, but it's a danger to which one must be alert.

Another concern is that extent to which workers at the community level redefine their jobs following program consolidation. It is not unusual for administrative and organizational barriers to remain even after funding streams simplify. This problem simply reflects history and human nature, I suspect. The point is simply that it takes time and hard work to really make programs work together, and that on-going monitoring and technical assistance is often required.

With these caveats in mind I remain an advocate of consolidating categorical programs.

2. Given the great variations across communities, and the peculiarities of local conditions, I'd always be reluctant to say that federal funds should only flow to programs that have a full complement of comprehensive services on site. In some instances, referrals are the best (or most feasible) way of helping pregnant women; moreover, many pregnant women need only minimal care and it

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is not cost-effective to have all back-up services instantly available. Nonetheless, there should be reasonable availability of support care and ancillary services, if only on a referral basis. Thus the test of program "worthiness" is not that everything is available to everybody instantly in one place--although such comprehensiveness is always nice--but that the referral network is very well-developed, efficient and humane, so that with minimal inconvenience, a high-risk woman can receive the comprehensive care she needs.

Please let me know if additional responses would be helpful.

Sincerely,

Sarah Brown

Sarah Brown
Study Director

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November 15, 1989

Joan Eberly, R.N., M.P.H.
Director of Personal Health Service
Berrien County Health Department
769 Pipeston
Benton Harbor, Michigan 49022

Dear Ms. Eberly:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Caring for New Mothers: Pressing Problems, New Solutions," on October 24, 1989. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by November 22 with any necessary corrections.

In addition, Representative Thomas J. Bliley, Jr., has requested that you respond in writing to the following questions so that they may be included in the hearing record:

1. What are some of the administrative problems you face with categorical programs?

2. How does the federal and state organizational structure affect local service delivery?

3. At the end of the project, Berrien County had a lower infant mortality rate than the statewide rate. What has the state done since then to impact the infant mortality rate?

4. To what extent do eligibility requirements vary from program to program?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

Enclosure

RESPONSE TO QUESTIONS POSED BY CONGRESSMAN THOMAS J. BLILEY, JR.

Berrien County
Health Department

November 29, 1989

U.S. House of Representatives
Select Committee on Children, Youth and Families
Thomas J. Bliley, Jr., Virginia
Ranking Minority Member
385 House Office Building Annex 2
Washington, DC 20515

Dear Representative Bliley:

This is my first day back in the office since the letter arrived with the additional questions you would like answered. Hope I haven't missed the deadline so they may be included in the hearing record.

1. What are some of the administrative problems you face with categorical programs?

   Categorical programs usually focus on well defined health problems which miss the broader health issues of an individual or family and in the strictest sense ignore the existence of other related services that could benefit the individual or family. Staff from one program cannot assist in another program, even though one may have down time due to "no shows" while another may be jammed. There is frequently duplication in record keeping and data reporting. It seems that each year there are additional budget columns and plans that are required. All must be administered independently, which adds to the manager's workload. WIC and DSCC are initiating a single computerized information and management system that will not interface with our local computerized system.

2. How does the federal and state organizational structure affect local service delivery?

   The organizational structure at the Federal and State level are categorical and reflect tunnel vision as far as any other related programs are

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concerned. They may exist in different bureaus or divisions and even display adversarial or competitive relationships, i.e. we have AIDS located in our Sexually Transmitted Disease Program; however, at the State level the S.T.D. Program is in the Bureau of Laboratory and Epidemiology, whose Bureau Chief said no staff funded by S.T.D. funds can deliver AIDS services. AIDS is situated in the Center for Health Promotion.

3. At the end of the project, Berrien County had a lower infant mortality rate than the statewide rate. What has the state done since then to impact the infant mortality rate?

   The state has targeted Berrien County for Infant Mortality Initiative Funds. But they do come to us with restrictive use that does not allow us flexibility in meeting our local high risk needs. They also change definitions from one year to the next so that a service we initiate one year does not meet the next year's criteria.

4. To what extent do eligibility requirements vary from program to program?

   - WIC (Department of Agriculture) is 185% of poverty. Teens must qualify according to parents income. Very strict instructions.
   - Prenatal Care - Medicaid - 185% of poverty where all teens qualify because they are teens.
   - Family Planning - 150% of poverty
   - E.P.S.D.T. - 100% of poverty - excluding the working poor families that have no third party medical insurance.
   - D.S.C.C. - financial eligibility allows for flexibility of family income - see attached.

Hope this information has helped.

Sincerely,

Joan Eberly, R.N., M.P.H.
Director of Personal Health Services

JE:bm

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 House Office Building Annex 2
Washington, DC 20515

November 15, 1989

Ms. Kathy Ruscitto
County Administrator for Human Services
County of Onondaga
John H. Mulroy Civic Center
421 Montgomery Street
Syracuse, New York 13202

Dear Ms. Ruscitto:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Caring for New Mothers: Pressing Problems, New Solutions," on October 24, 1989. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by November 22 with any necessary corrections.

In addition, Representative James T. Walsh of New York, has asked that you and Dr. James Miller respond to the following questions in writing submitted the following questions so that they may be included in the hearing record:

1. In your estimation what has led to the rising infant mortality rate in Onondaga County, and is it primarily drug related? Are these deaths due to low birth weight or are they attributed to other factors?
2. If improved coordination among services seems to be the focus of your recommendations, where should the leadership stem from, government- schools- community?
3. What is the relationship between teen pregnancy and infant mortality?
4. In the report on Access to Health Care and the visit to Toledo, Ohio, there was extensive discussion regarding the relationship between hospitals and services. The report seems to support merging hospitals clinics and social service efforts. What obstacles do you envision in implementing this model?

5. It would seem to me that the federal government needs to work with the states to ensure that maternal and child health care is available, but more importantly that it is accessible. What other obstacles have you identified related to access?

Let me again express my thanks, and that of the other members of the Committee for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

Enclosure

DEC 1 2 198

COUNTY OF ONONDAGA

Office of the County Executive

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Nicholas J. Pirro
County Executive

[illegible]
[illegible]

Edward Kochian
Deputy County Executive

[illegible]
[illegible]

December 5, 1989

George Miller
Chairman
Select Committee on Children, Youth and Families
385 House Office Building Annex 2
Washington, DC 20515

Dear Mr. Miller,

RESPONSE TO QUESTIONS SUBMITTED BY CONGRESSMAN WALSH

1) In your estimation what has led to the rising infant mortality rate in Onondaga County, and is it primarily drug related? Are these deaths due to low birth weight or are they attributed to other factors?

During the next several months we will carefully analyze the deaths of infants that have occurred in Onondaga County. Our initial beliefs are that we will find a high correlation with maternal age, income, lack of prenatal care and poor follow-up care during the first year of life. In addition we will categorize the exact causes as cited on our death certificates.

2) If improved coordination among services seems to be the focus of your recommendations, where should the leadership stem from, government- schools- community?

At this time, County government is providing the leadership. In order to be effective there must be direct involvement with schools and community agencies. Government services such as WIC, Medicaid, Food Stamps, Well-Child, Day Care Subsidies, and TASA (Teen Age Services Act) must be coordinated with schools and community agencies to be effective. For example: This summer a team from our Dept. of Social Services went into a local high school to register students who might be eligible for Day Care Subsidies. In one morning thirty students were registered at once. This spring we will be co-locating with a local hospital's OB-GYN clinic to provide on-site application, case management and follow-up services.

3) What is the relationship between teen pregnancy and infant mortality?

The relationship between teen pregnancy and infant mortality will prove to be linked. Teen pregnancy is generally characterized by late or little prenatal care, and therefore low birth weight. As concerned as we are for infant deaths, we must be equally concerned about the long term effects on the health of low birth weight infants. Case management services must be stressed for this population to ensure they seek and receive prenatal care.

4) In the report on Access to Health Care and the visit to Toledo, Ohio, there was extensive discussion regarding the relationship between hospitals and services. The report seems to support merging hospitals clinics and social service efforts. What obstacles do you envision in implementing this model?

The obstacles we expect to encounter include:

- lack of reimbursement for outreach services;
- lack of Medicaid eligibility and coverage;
- limited local funds to establish new models.

The positives we have already encountered include:

- interest on behalf of all community agencies in coordinating services;

- securing of several State grants to pursue studies in this area;

- local planning efforts have already encouraged changes to enhance the system.

5) It would seem to me that the federal government needs to work with the states to ensure that maternal and child health care is available, but more importantly that it is accessible. What other obstacles have you identified related to access?

The eligibility and coverage available through Medicaid must be expanded and simplified to ensure women will seek prenatal care. We are exploring instituting an additional Medicaid HMO, as well as working with the Medical Society to develop a rotation system for Medicaid clients to expand the number of participating physicians.

Sincerely,

Kathryn H. Ruscitto
County Administrator-Human Services

KHR:wlo

PREPARED STATEMENT OF JONATHAN B. KOTCH, M.D., M.P.H., CHAIR, COUNCIL ON MATERNAL AND CHILD HEALTH, NATIONAL ASSOCIATION FOR PUBLIC HEALTH POLICY CHAPEL HILL, NC

CARING FOR NEW MOTHERS: PRESSING PROBLEMS, NEW SOLUTIONS

JONATHAN B. KOTCH, M.D., M.P.H.

Thank you for the opportunity to submit written testimony on the subject of barriers to maternity care. I commend the Select Committee for addressing this issue under the rubric of "New Solutions." Indeed, drastically new initiatives are called for if the United States is ever to join the ranks of other industrialized countries which have continued to improve their low birthweight and infant mortality rates in the 1980's while those of the U.S. have remained essentially stagnant. On the very day that the Select Committee was holding its hearing in Washington, D.C., October 24, 1989, I was privileged to be present at the American Public Health Association's presentation of the Young Maternal and Child Health (MCH) Professional of the Year Award to Dr. Samuel Kessel, Director of the Division of MCH Program Coordination and Systems Development, Bureau of MCH and Resources Development, USDHHS. At that session, Dr. Vince Hutchins, Deputy Bureau Director and head of the Office of MCH, reluctantly announced that the standing of the U.S. among the world's developed (and not so developed) counties in infant mortality had slipped to 22 despite the efforts of all of us at federal, state, and local levels. A new solution, therefore, is urgently required.

In examining barriers to care, health services research people distinguish between system barriers and client barriers. Defensive providers resort to excuses for failing to enroll pregnant women in early prenatal care by citing charactics of the women. Undoubtedly there are such characteristics, but lack of education, lack of information, lack of transportation, even lack of motivation are not inherent among such women but are themselves social problems. It is unlikely that a health service provider can overcome decades, if not generations, of poverty, discrimination, and injustice.

Health providers and policy makers can address system problems. In this brief testimony I would like to offer a radical proposition, namely, that Medicaid is part of the problem, and not part of the solution. We will soon be "celebrating" the 25th anniversary of Medicaid, yet during that period, the status of the U.S. infant mortality rate relative to those of other developed nations of the world has declined. The availability of providers willing to accept indigent pregnant women has declined, while the number and proportion of Americans uninsured for medical expenses, particularly those Americans in their prime reproductive years, has gone up. Teenage parenthood and single parenthood, two risk factors associated with risk of low birthweight and infant mortality, have also gone up. These are evidence of system-wide failure, yet we continue to consider piecemeal solutions which only tinker at the margins, solutions which have failed at every step to keep up with the pace of deteriorating circumstances among the weakest and most vulnerable of our population.

Because of the dearth of evidence to explain why Medicaid is part of the problem, I can only speculate. One probable cause is that no reimbursement program can address the need to reverse the decline in available providers. Reimbursement systems assume that the providers are out there, and that they will accept the reimbursement. In the case of Medicaid for pregnant women, the evidence shows that neither of these assumptions is correct. It is clear that, regardless of the level of reimbursement, a substantial number, over half at the present time, of private providers of obstretrical care refuse to serve Medicaid clients. This may be in part due to unfounded fears of suit in the case of a bad outcome, but it is likely that many obstetrical providers in the private sector just do not feel comfortable with indigent clients, and they know that their paying customers would undoubtedly feel uncomfortable sharing a waiting room with poor and minority women.

A second probable explanation of why Medicaid is part of the problem is precisely that the services provided by Medicaid providers are not appropriate for the particular needs of Medicaid-eligible women. There is some evidence that women on Medicaid do less well that indigent, non-Medicaid women. In North Carolina, Dr. Paul Buescher published in State Center for Health Statistics Studies, No. 39, March, 1986, that the risk of Medicaid women having low birthweight babies was more than twice as great as that of a statistically comparable population receiving prenatal care in a public health department.

A third probable explanation of why Medicaid may be part of the problem is that focussing on payment for prenatal care blinds us to underlying causes of the low birthweight and infant mortality problems which occur prior to conception. Analyses of public programs to reduce low birthweight and neonatal mortality by Joyce, Corman, Grossman and others have demonstrated that the cost-effectiveness of access to family planning services, including abortion, exceeds in some cases that of early access to prenatal care. The social agenda of political leaders in the 1980's has precluded consideration of the role of barriers to family planning services in our relative increase in infant death compared to other developed countries.

Since 1963, we have had a model of a successful medical care program for reducing low birthweight and infant mortality, namely, the Maternal and Infant Care Projects (MIC). These projects, whose 25th anniversary can and will be celebrated in New York in December, demonstrated that comprehensive, coordinated, community-based services, utilizing mid-level providers including nurse midwives, offering care for the entire reproductive cycle without onerous eligibility screening, can reduce low birthweight and prematurity for low income, pregnant women at reasonable cost. The forces of cost containment and New Federalism have attempted to replace these service-oriented models with the failed reimbursement models we are left with today. The time has come to admit that, in the case of care for women and children, this expedient is crying out for a "new solution."

That new solution is Universal Maternity Care. The Council on Maternal and Child Health first proposed Universal Maternity Care in 1982. Since that time, many other organizations, including the Americal Academy of Pediatrics and the National Commission to Prevent Infant Mortality, have adopted the slogan of universal access. However, the question, "Access to what?" remains. The Academy's plan offers access to insurance, not access to care. The Commission has called for assuring universal access to care, but doesn't offer any mechanism for guaranteeing that women in need actually get care. In order for that to occur, government must be ready and willing to provide services where they do not exist or where they remain inaccessible to poor women. The Council on MCH proposal would replace Medicaid with a single payor in each state, expand the availability of services by enfranching non-physician providers, create a single maternity care system while taking advantage of a variety of provider organizations, create standards of care and surveillance of outcomes, and provide for a federal role in guaranteeing receipt of services. If maternity care is to be truly universal, it must be stripped of the stigma associated with means-tested welfare programs. Going to early prenatal care should be not be any more difficult than going to kindergarten. It is no less important.

Thank you again for the opportunity to submit this testimony. A copy of "Principles of Universal Maternity Care" is attached.

NAPHP NATIONAL ASSOCIATION FOR PUBLIC HEALTH POLICY

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Principles of Universal Maternity Care

Council on Maternal and Child Health

National Association for Public Health Policy

October 30, 1987

Eligibility.

1. Every pregnant woman in the United States must be guaranteed access to comprehensive maternity and infant care regardless of location or ability to pay.

Services.

1. Comprehensive maternity and infant care services, for the purposes of this proposal, are the full range of maternity care services, including but not limited to early and continuing prenatal care, medical, psychosocial, educational and nutritional services, and postpartum care including family planning services, as well as in-patient neonatal services and well-child services up to the 18th month of life.

Providers.

1. Pregnant women must have choice of providers from among all licensed medical and health providers including both physicians and certified nurse midwives as well as from among organized providers of prenatal care such as health departments and community health centers.
2. Pregnant women must also have the ability to deliver in an appropriate, licensed location including both JCAH-certified hospitals and accredited birthing centers.

Financing.

1. Medicaid eligibility, for the purposes of maternity and infant care, will be nationally mandated at 185% of poverty for the pregnant woman and her unborn child. Income, not family structure, employment, assets or other tests of means, will be the only consideration.
2. A sliding scale for the purchase of Medicaid coverage by families with incomes between 185 and 250% of poverty will be established.
3. All federally qualified employee health benefit plans must be required to offer first dollar coverage for maternity and infant care benefits without co-payment or deductible. Employer and employee contributions to this coverage will be tax-deductible.
4. All employers of 10 or more employees will be required to offer a health insurance benefit plan covering maternity and infant care, including the the option of purchasing the partially subsidized Medicaid plan for low wage workers.
5. Employers currently providing maternity care benefits will be required to maintain those benefits at the same level.

6. Federal-state matching funds via the MCH Block Grant will be required to provide the resources necessary to cover pregnant women who are uninsured, i.e., without either Medicaid or a private maternity care plan.

Reimbursement.

1. Provider reimbursement will be based upon an annually negotiated payment adequate to cover all routine and medically indicated care. Such payment may vary according to medical risk and among medical market areas and categories of providers.
2. Each state will establish a quasi-public fiscal intermediary, the Maternity and Infant Care Trust, funded through premium payments from all participating public and private sources of maternity and infant care coverage, which payments will be based upon the actual maternity care experience of the participating third party payors.
3. Providers will be guaranteed timely reimbursement at 100% of the negotiated fee levels, and hospitals will be guaranteed full reimbursement for the actual cost of maternity and neonatal care services.

Liability.

1. Providers will be considered agents of the state when caring for women and infants participating in the maternity and infant care plan, with the protection from suit that such status implies as long as they provide an acceptable level of care.

Administration.

1. Federal administration of the program will be the responsibility of the Office of Maternal and Child Health, Bureau of Maternal and Child Health and Resources Development, USDHHS.

2. The Secretary of DHHS will establish a national advisory board with the authority to recommend minimum standards of care for participating providers and hospitals. In those cases where state standards are more stringent, such state standards would apply.
3. State Health Departments will be responsible for the certification of participating providers and hospitals, for the enforcement of standards, for data collection, and for that technical assistance, consultation, and continuing education necessary for assuring that resources required for the provision of services to all pregnant women and infants in need are available in a timely manner.
4. MCH Block Grant funds, ear-marked for this purpose, will be required to provide necesary incentives and resources to guarantee that services are available when and where needed.

PREPARED STATEMENT OF SANDY JONES, CONSULTANT TO FRIENDS OF THE FAMILY, BALTIMORE, MD

[Sandy Jones is a nationally known consultant on services to parents. She is the author of six published books on parenting, including To Love a Baby which won the "Distinguished Contributor Citation" of the National Media Awards of the American Psychological Association. Her full report which examines services to Baltimore's indigent parents and model programs for serving them nationwide is entitled MOTHERS, FATHERS AND BABIES: A WORKING PAPER ON THE ISSUES FACING BALTIMORE'S YOUNG, LOW-INCOME FAMILIES. It will be published in January, 1989, by Friends of the Family (2300 N. Charles St., 5th Floor, Baltimore, MD 21218)].

I was commissioned last year by Friends of the Family, a non-profit organization which offers technical support to family support centers in the State of Maryland to study services to pregnant women, children 0-3 and their families in the City of Baltimore. The funds for the study primarily came from local foundations including the Abell Foundation.

The delivery of health services to pregnant women, infants and their mothers in Baltimore is of serious concern. In 1984, Maryland's infant mortality rate was 11.1 deaths per 1,000 live births.[1] A racial disparity was evident -- 16.6 per 1,000 for black babies, but only 9.0 per 1,000 for white babies. The state was ranked as having the 10th highest infant mortality rate in the nation, while, ironically, it had the 7th highest per capita income.[2] In 1986, the City of Baltimore had the highest white infant mortality rate in the nation for cities with 500,000 or over. The rate was 16.2 deaths per 1,000 live births in comparison to 11.7 for the state. The rate for white infants was 12.6 per 1,000 live births, but for black infants it was 18.2 per 1,000. Of the 255 babies who died during their first year in Baltimore in 1987, 78% were black.

Provisional figures for the city in 1987 show that the overall infant mortality rate has risen to 18.9 deaths per 1,000.[3] The infant mortality rate in Rosemont a mostly black community, and one of the city's poorest sectors is 29 per 1,000 -- making survival more likely in Trinidad, Cuba, or Jamaica, than in Baltimore.

A study of indigent black women in Chicago by Dr. Kathryn Vedder of the Illinois School of Public Health found that women between the ages of 25-35 were more likely to have a higher incidence of infant mortality than were women in their teens. White women in that age range, on the other hand, were more likely to have good birth outcomes.

Similar outcomes were found for Maryland. A survey conducted by Peter Shafer, Staff Specialist of Maryland's Maternal and Child Health at the Division of Health Systems

Financing Administration of babies in Maryland's Medicaid Program who have engendered the highest costs in neonatal intensive care units found that indigent pregnant women in their 20's with more than one child, may be more at risk for serious outcomes than adolescent mothers.[7] The highest percentage of extremely high risk babies (50%) were born to Baltimore women who were 21-30; while only 9% of babies were born to women under 17 years of age.[7] Multiparous women, those who have given birth to more than one child in the past, were far more likely to give birth to high-risk infants than first time mothers, 67% had more than one child in contrast to 33% who were giving birth for the first time. While 83% of the extremely high risk infants were black, and only 17% were white.

Even though sixty-eight per cent of the women could be termed as having an adequate numbers of medical visits, Shafer points out that the problem may not be so much a lack of care as the inherent inadequacy of care. It could be noted that the majority (59%) of the babies had been born to mothers who received their care in hospital-based clinics. Clearly, the 66% divergence between the number of highly at-risk black babies in contrast to white babies in Shafer's survey would indicate serious inequities in healthcare delivery and socioeconomic support that need to be addressed in our city.

Low-income mothers should be considered at risk of physical maladies and poor outcome. Dr. Janet Hardy, Professor Emeritus of the Johns Hopkins School of Medicine found that 53% of young, low-income, multiparous mothers in her Baltimore study reported being anemic, and 17% of them reported that they went hungry at times during pregnancy because of insufficient food.[8]

Yet, when one interviews administrators of health care programs in the city, it is clear that they feel that the services available to Baltimore's indigent mothers is adequate, and that it is the patients themselves who are non-compliant and do not want to avail themselves of the care.

Dr. Hardy disagrees with that stance. She stated in an interview in March of 1989: "Baltimore has medical services fo. poor families, and some are very good. But, for the most part, services are desperately inadequate in terms of meeting the need. If they were adequate, people wouldn't be having unwanted children. If they were adequate, people would be getting WIC when they needed it. If they were adequate, poor children would be getting health care, but only half of our poor children are getting the health care they need."

Similarly, Dr. Ronald L. Gutberlet, Chairman of Pediatrics, Mercy Medical Center and President of the Maryland Perinatal Association points out the serious financial shortfalls which are affecting the quality of care to indigent, pregnant women. In **The Perinatal Record of the Maryland Perinatal Association** (Winter, 1989), he states: "Despite the best efforts of many doctors, nurses, social workers, administrators, public health professionals and other individuals to provide quality perinatal care to this population, the programs in which they work are not only grossly underfunded by all levels of government but also are hampered by inadequate facilities, insufficient personnel, and inadequate funds to purchase services."

"There is a misconception that services provided in a Baltimore City prenatal clinic are the same quality that patients receive in a private obstetrician's office. It is simply not true. I've worked with patients in contracted services in downtown, and the services are not as good as out in the suburbs. The equality of care is not there despite the efforts of many people to provide it," he noted in an interview last year.

Dr. Gutberlet noted the run-down quality of the physical plants of the clinics most of the downtown clinics are located in old buildings with "60 coats of paint on the walls and old wooden floors. Despite of what people try to do with the clinic areas, they are mostly crowded and outdated, and have been put into renovated office buildings or houses to try to provide something. Location is an issue. Obviously, a mother who lives in a downtown housing project isn't going to take a bus out to the suburbs to see an obstetrician," he said.

Obstetricians in the city have washed their hands, for the most part, of indigent Medicaid patients who seek obstetrical care. A telephone survey of the twenty obstetricians advertising their practices within Baltimore City limits found that only two were willing to see Medicaid patients, and only one in his own office.

Obstetricians believe that low-income patients are at once more at risk of poor birth outcomes and more likely to sue for malpractice (which does not prove to be true in studies of the rates of malpractice suits according to income). Doctors also complain that the level of Medicaid payment they receive is insufficient to offset the high costs of malpractice insurance. The paperwork demands of the program make it "not worth it" to them.

The clinics themselves which deliver services to poor, pregnant women were found to have serious problems with day-to-day management which included: inefficient appointment systems; prolonged waiting periods for patients; insufficient follow-up; and the lack of continuity of care.

Clinic managers state that one of the main reasons for patients having to wait long periods is the difficulty in scheduling physicians. Other obstacles to smooth functioning were unanticipated patient delays in getting special tests, short clinic hours, high patient-to-staff ratios, and inadequate support staff. Clinics often had been allocated inadequate space, and the lack of centralization within the clinic required that patients navigate complex hallways and floors to have laboratory tests performed, to have drugs dispensed, or to locate educational materials.

The appointment structure in hospital-based clinics is a critical flaw, I believe. Appointments were scheduled in blocks of time, rather offering patients individual, timed appointments. Thus, all the women coming to a clinic were told to sign in at 8:30 a.m., and then all of the patients for the day were expected to sit and wait to be seen. As a result, pregnant women were unable to predict the amount of time required, or how long their other young children would require care, and, in many cases, one or more hours are spent in the waiting area, or semi-nakedness in an examining room before seeing a doctor.

Middle- and upper-income obstetrical patients in the suburbs would not be likely to accept such scheduling and disrespect for the importance of the individual.

Even though low-income pregnant women should be considered as "high risk" patients, most hospital clinics treated them as extremely low risk. That is, patients were subjected to being treated by a steady (and inconsistent) stream of inexperienced interns and residents rather than well-seasoned obstetrical specialists with strong backgrounds in high risk intervention.

Often administrators of programs on the state and local level seemed to be oblivious to the feelings and needs of their patients. One HMO in particular reported that they assigned a different physician each time a mother came in "on purpose," because they didn't want the mother to think that she would have a certain doctor for delivery. Few women who were paying for medical care would be satisfied with such a callous policy that overlooked their need for continuity and familiarity of care.

When asked about how they felt about Baltimore's clinics, most mothers expressed unhappiness with services being offered. They commented on overbooking, drab, unfriendly waiting areas with uncomfortable plastic chairs, half day waits to be seen, surly staff members who are always in a hurry, and the problems of trying to deal with bored hungry, young children who cried and ran rampant while their mothers tried to get care. They complained of not being able to get appointments for weeks, or longer, so that in their critical early stages, when ambivalence and uncertainty were at their highest, and that they often could not find prompt diagnosis and treatment. Perhaps they should speak for themselves:

> *"I hate the clinics and I don't like the way doctors treat you there. They didn't explain what is going to happen to you. They hurt you, but they don't prepare you for it. Their attitude is like: 'so?' It made me not want to go to doctors. I'd get a different doctor each time. If I didn't get in there early I would have to wait 3-4 hours. They'd take your blood and urine, and then you'd sit for hours waiting for the doctor. They weren't very explanatory. They didn't say what was going on. They talked big 'doctor words'."*

> *"If doctors are just in it for the money, they have forgotten why the true reason for being in medicine. Pregnant women in Baltimore who are on Medicaid hate going to clinics. We would go to private physicians if we could, but we don't have any other choice. They make you wait for hours in the clinics, and the staff treat you like you*

are 'low life' -- like they're not getting paid to help you. The doctors are always in a hurry and act like they don't have time to sit and discuss your problem. Some patients are too proud, they don't want to ask questions because they don't want to seem stupid. I made out a list of questions, but the doctor acted mad because I was taking so much of his time. He walked out of the room saying that he had to go see another patient. Doctors that work with poor people should be sensitive and sympathetic to our needs."

……

"You never see the same physician twice in the clinic. It's so jammed and there's only one doctor there. You talk to one doctor one month, and it's a different one the next time. You never know who you will see. I went to a private O.B. for awhile and it was much different. While a clinic will make an appointment for 9, you may not see the doctor until 10 or 11, but the private doctor saw me in 20 minutes."

[Interviews conducted January, 1989].

I believe that a strong effort is needed on state and city levels to solicit the feedback of low-income childbearing women such as these in our city. And then, there needs to be committed, longterm work with health care professionals, medical societies, and clinic administrators to make radical and humane changes on the front lines of health care delivery.

Better, more realistic funding and more efficient reporting systems are needed to improve the overall facilities and staffing of prenatal programs. The process of Medicaid billing needs to be streamlined and the level of payment given to obstetricians raised in order to encourage participation by physicians.

The ethical issue of doctors refusing to take on indigent, pregnant women is something that should be brought before our city's and the nation's medical societies.

The cost of not providing adequate prenatal care to Baltimore's pregnant women is enormous. Over the next decade the successive costs of providing lifetime care and treatment to each year's group of low birthweight babies born here (and the health department states that there are over 2,000 of them) whose outcomes could well have been prevented by appropriate care, can be projected to exceed $1 billion.

More important than the financial considerations, I believe, is the call for compassion and humaneness. Every low-income pregnant women has the intrinsic right to equal and fair medical treatment offered with dignity and respect, regardless of her race, her socio-economic status, or her ability to pay. And this is where our city's medical systems and providers appear to be failing most acutely.

A Baltimore Physician Comments on the Rights of Pregnant Mothers

"The people in Baltimore's poor communities should have access to the same medical care as anyone else. They should not be treated any differently. They should receive the same benefits. I feel it is an obligation of physicians to ensure that this quality delivery of services is a part of practicing medicine.

The continuity of prenatal care is the Baltimore's biggest problem. Pregnant women should be treated like they are special, not like another routine clinical case. The person whom a mother sees in the prenatal clinic should be the same person she'll see at the hospital and for her postpartum care. Mothers need a setting and people with whom they can identify with and whom the can continue to see each time that they return for care.

As a physician, it is rewarding to work with indigent mothers. It's nice to see healthy babies and know you are helping to deliver a higher standard of care to the city's poor."

A Baltimore Obstetrician who has been delivering care to indigent mothers for ten years in addition to his private practice.

NOTES

1. Otten, Alan L. "Slowing drop in infant death rate fuels debate on U.S. spending for child, maternal programs." Wall Street Journal. July 23, 1985.

2. Maryland Governor's Commission on Black and Minority Health. Now is the Time: An Action Agenda for Improving Black and Minority health in Maryland. Final Report. November, 1987, p. 106.

3.Baltimore City Health Department. The Baltimore Project: A Model Pre-Natal Care and Follow-up Program. (A proposal submitted to the Abell Foundation by the Office of Policy Coordination for CHildren and Adolescent Services of the Office of the Commissioner). November, 1988.

4. Peter Shafer, Staff Specialist of Maryland's Maternal and Child Health at the Division of Health Systems Financing Administration. Unpublished findings. Interview: February 9, 1989.

5. Specific age breakdowns: 9% to women under 17; 31% to women 17-20; 29% to 21-25; and 21% to 26-30.

6. Hardy, J.B., C.B. Flagle, A.K. Duggan, et al. Resource use by pregnant and parenting adolescents. Unpublished manuscript: The Johns Hopkins University Schools of Medicine, and Hygiene and Public Health. Baltimore, MD, 1986.

ARC Research Foundation

November 6, 1989

The Honorable George Miller
Chairman
Select Committee on
Children, Youth, and Families
U.S. House of Representatives
385 House Office Building Annex 2
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed are several copies of testimony prepared at your invitation, to accompany the record of a hearing held October 24, 1989, by the Select Committee on Children, Youth, and Families, on "Caring for New Mothers: Pressing Problems, New Solutions."

This written testimony is based in part on my research on infant mortality and high-risk pregnancy among disadvantaged women in Washington, D.C., where the rate of infant death remains the highest in the nation and where poor women are in particular need of innovative approaches to health care. The testimony is also based on an analysis of national data compiled for my recently published book, CAPITAL CRIME: BLACK INFANT MORTALITY IN AMERICA (Sage Publications, 1989).

I appreciate your kind invitation, and look forward to working with your staff, in particular Jill Kagan, in the future.

Sincerely,

Margaret S. Boone, Ph.D.
Project Coordinator
Addiction Recovery Corporation
Research Foundation

and

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PREPARED STATEMENT OF MARGARET S. BOONE, PH.D., PROJECT COORDINATOR, ADDICTION RECOVERY CORPORATION RESEARCH FOUNDATION, ROCKVILLE, MD AND ADJUNCT ASSOCIATE PROFESSOR, DEPARTMENT OF PATHOLOGY, GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE & HEALTH SCIENCES, WASHINGTON, DC

Summary of the Major Points in This Testimony

This testimony suggests, specifically: (1) the design and implementation of "culturally appropriate" maternity programs especially tailored to the needs and values of poor minority groups, (2) the development of forums and other mechanisms where experts in health care services and experts in culture and community can come together to develop applications of the knowledge we already have about the minority poor, (3) the integration of AIDS prevention and education in all maternity programs, with special emphasis on effective communication between conjugal partners, (4) inclusion of social support mechanisms in all maternity programs for the minority poor, especially for women who are in substance abuse treatment, (5) development of focused, concentrated educational efforts on substance abuse, which must precede the widespread success of general education programs, and (6) encouragement by health care services of all efforts to bring men back into the process of keeping their partners and children healthy.

Data Sources, Funding Support, and Analysis

This testimony is based on a three-part research effort to understand high infant mortality rates among the urban poor. The first part of the research was funded by the National Science Foundation in 1979-80; the second part was supported by the U.S. Census Bureau in 1983-84; and the final analysis of the combined data base was completed in 1987, and published in 1989, in a book entitled CAPITAL CRIME; BLACK INFANT MORTALITY IN AMERICA (Sage). This research effort involved the collection and analysis of a great deal of social and health data on inner-city women who delivered infants at the District of Columbia General Hospital in the late 1970s. While other risk factors have developed since that time--specifically, crack cocaine and AIDS--fundamental issues and mechanisms remain the same. In fact, the potential exists for the development of even more serious risk factors, and for continued, if not increasing rates of poor pregnancy outcome.

Health care delivery for poor minority American women has in the past been hampered because our knowledge of these women is difficult to use in the implementation of maternity health care programs. The goals of this testimony are (1) to provide some understanding of the need for linkage between our knowledge of minority women and the development of maternity programs for them, and (2) to make recommendations based on the analysis of national level data.

As long as even our present knowledge of their special needs and characteristics remains unincorporated in maternity care programs, poor women will remain at considerable--and now in the District of Columbia, at increasing--risk of suffering a poor pregnancy outcome, and, America's infant mortality rate will remain embarrassingly high.

This testimony is based in part on the development of an integrated explanation for Washington, D.C.'s rank as Number 1 in infant mortality rate, and more broadly, on explanations of why large metropolitan areas in the United States contain very high-risk minority populations.

Barriers to the Design and Delivery of "Culturally Appropriate" Approaches to Maternity Care for the Minority Poor

A great deal of good work has been completed in the past two decades in the area of prenatal care for American women in general. A recent National Academy of Sciences panel found that the American health care system is, for the most part, doing well in providing prenatal health care for most pregnant women. Yet, high-risk pregnancy is concentrated among the urban and rural poor, and often in groups of Americans whose attitudes, beliefs, and cultural practices may make outreach particularly difficult. The same approaches to prenatal care among mainstream American women do not always work well among the urban poor and ethnically distinct.

The health care system is now challenged to develop and deliver "culturally appropriate" maternity and infant health care programs, and to modify--if necessary--the approaches developed for the large majority of American women. This is a very difficult, sensitive task, for two principal reasons:

(1) While it may be a simple matter to call for "culturally appropriate" health care programs, it is very difficult to design and implement them. It is difficult to operationalize our knowledge of sub-cultures in the construction and delivery of practical, effective programs.

Therefore, one of our major goals should be the linkage of knowledge gained in research specifically among the minority poor to specific, practical components of maternity programs. This will take creativity, innovation, and some courage. Our knowledge of sub-cultures and lifestyles among the poor is considerable. Yet, we have not incorporated that knowledge widely and well to date. Health care services research and basic, sociological research on specific American groups are difficult to link together. Not only do we need more basic research, but we need more linkage between basic research and the delivery of services.

(2) The second reason for difficulties in the development of "culturally appropriate" programs is a natural tendency to remain with familiar approaches and to define health problems in familiar idiom. For example, "culturally appropriate" programs may appear intuitively counter-productive--or simply unfamiliar and foolish--to health care workers at all levels who are accustomed to standard approaches to maternity care which work well elsewhere.

A prime example is the notion of the "availability of prenatal care." "Availability" must take on new meanings vis à vis minority women. It might appear nonsensical to offer prenatal care to non-student women in a local elementary school clinic between 7 and 10 o'clock in the evening. Standard notions of "availability" imply that a woman can make an appointment for health care, drive to her appointment, that she can get there in standard hours between 9 and 5, and, moreover, that all of her peers approve of and encourage her to get prenatal care. However, this notion of "availability" doesn't match the inner-city woman's experience or capabilities. The inner-city woman often has no car to drive, she may not be able to come between 9 and 5, and her peers in her community may not place a high priority on her obtaining prenatal care--often from doctors and nurses whom they may fear. The people most important for inner-city women--those in her community--may not focus on the future health of the woman and child, but on more immediate needs such as food, rent, and comfort--which too often now takes the form of substance abuse. Maternity care necessarily involves preventive, future-directed action which is not a familiar mode of action or thought for many poor women who are simply trying to live through each day. In light of these differences, "availability" of health care must take on new meanings.

Other examples of "culturally appropriate" efforts come from the many demonstration projects now ongoing to decrease the risk of HIV infection among intravenous drug abusers in the same poor, minority groups. For example, a program for Afro-Americans might make particular use of "rap sessions" with local ministers; or, provide housing or job-finding assistance in a more integrated program; or, involve telephone networks to recruit participants. All of these factors have been found to work in a NIDA-supported demonstration program called "COPE," in Hartford, Connecticut (Singer et al 1989). These same types of innovative, close, face-to-face, community and network innovations should be attempted among maternity patients. Enlistment of poor, minority women should make use of the already existing social structures in her community.

In summary, one of our major goals should be the linkage of knowledge gained in research on the poor and on special ethnic groups such as Hispanics, Afro-Americans, and refugee groups, to practical delivery systems. This requires support for innovation from health policy makers, but then, once demonstration projects have been evaluated, for the widespread implementation of new approaches. It also requires the interaction of researchers and health care personnel. At the present time, there are few mechanisms to routinely bring together health care personnel, health care services researchers, and social researchers in the same forum to develop practical applications of sometimes all-too-esoteric social research findings. While new research will continue to expand our knowledge of the psychological, social, and attitudinal barriers to effective use of maternity programs, the application of what we already know about minority sub-cultures can begin immediately to improve compliance. What we need are vehicles to bring together teams of experts in health care services, experts in culture and society, and local program managers and workers. It is extremely difficult to get all these leaders and experts together, but very effective when it happens.

Demographic and Historical Factors Which Create Special Needs in the Design of Maternity Programs for the Minority Poor

Rural-Urban Migration. Physicians, nurses, psychologists, and social workers confront each day barriers to effective health care in the form of differences in attitudes and practices regarding reproductive health among the minority poor. The attitudes and beliefs of poor urban Blacks, for example, have roots in the rural South. The large-scale migration of American Blacks from the rural South to the urban North earlier in this century has enormous consequences for the present-day reproductive health of inner-city women. In the space of one generation, the Black American population changed from three-quarters rural to three-quarters urban.

Wherever we find that magnitude of rural-urban change, we see an enormous amount of strain--as lifestyles, values, and customs regarding family formation change dramatically. Rural, conservative, southern community values at one time supported women who became pregnant very young. The history of youthful childbearing, as well as relatively early curtailment of childbearing among American Blacks, has a long history in the United States. Yet, when the same reproductive cycle is followed in northern cities, young pregnant women do not find the support that once existed. Other values and activities take precedence.

In the absence of good occupational and educational opportunities--childbearing becomes the main way that young women prove their worth. If and when this avenue fails, they often resort to "easy solutions" including cocaine and heroin abuse, smoking, and finally, for too many women in their older reproductive years, to alcohol abuse. The system of relief from daily burdens is intrinsically self-defeating, and results in further poor pregnancy outcome.

The origin of inner-city Black values in the rural South has special consequences in the area of AIDS prevention and education for mothers and their children, as well in our efforts to teach young women to space their pregnancies with the effective use of contraceptives. Conservative southern values originating in migrant populations earlier this century still inhibit the frank discussion and exploration of contraceptive use and AIDS prevention among the urban poor. Communication effectiveness between conjugal partners consequently affects the health of mothers, fathers, and their children, and will become an increasingly critical factor in the rate of spread of HIV infection among the urban poor. This will cause both maternal and infant mortality to rise once more. AIDS prevention, itself, becomes an enormously important component in all maternity and infant health care programs, from now into the foreseeable future.

How can health care services substitute for community support? This seems like an enormous task, perhaps even an inappropriate one from the perspective of some policy makers.

Yet, this is precisely what successful maternity health programs for the poor do. They offer group support, as well as some assistance in job-training or job-finding. Group support is an integral part of the type of focused educational programs needed among the minority poor. My own research in Washington, D.C., where infant mortality rate remains the highest in the nation, suggests that, until substance abuse is removed as a threat to the health of mothers and infants, broad-based education of minority women will have little effect. Educational programs for minority women must first focus on substance abuse, contraceptive effectiveness, and AIDS prevention before general education programs can hope to have an effect. Until then, education will not have the expected effect of improving community health.

Ironically, some of the best models for the provision of services to young, poor women may come from middle-class models, especially "self-help groups." Recruitment networks of friends and kin which enlist young women in maternity programs will also naturally tap two important social structures in the inner city: the female network and the female-headed family. The importance of the female group and of the provision of health care in a group format has also been emphasized in the delivery of, for example, substance abuse treatment. Kane found that group-based alcohol treatment was the best structure for inner-city women in New York. Only the social interaction of the group was adequate to substitute for the relief achieved through substance abuse. This is a familiar tenet in widely accepted programs such as Alcoholics Anonymous: Social interaction substitutes, in part, for the substance abuse. That same social interaction is important in maternity health programs among the minority poor, and critically important for one of the highest-risk groups in the inner-city: The pregnant teen substance abuser. While the proportion of substance abusers among teens is less than for women in their 20s, the teen substance abuser presents a great challenge to outreach workers because of her youth, dependency, vulnerability, and potential for a future, lengthy history of poor pregnancy outcome.

The Black Baby Boom Generation, intra-urban migration, and the development of an impoverished inner city. The 1970s and the 1980s have seen the deterioration, comparatively speaking, of inner-city health in several "lifestyle epidemics." The latest of these are the crack epidemic and the homicide epidemic associated with substance abuse--both of which find expression in higher maternal and infant mortality rates. These two decades have been particularly troublesome for poor inner-city Blacks. It is a time that other American Blacks have made significant gains in occupation and education, especially in large northern metropolitan areas.

The 1970s and 1980s have emerged as troublesome decades partly because they are the decades in which the large, post-World War II Baby Boom generation began their own families. The Black Baby Boom was proportionately greater, and lasted longer, than the White Baby Boom. With successful, upwardly mobile Blacks moving from inner-city neighborhoods to the suburbs, a large disadvantaged population was left. It was a time when community constraints were loosening. There was a great deal of occupational competition as young Black men and women entered the labor force. The Black migrations northward ceased in the 1970s, and with them, the renewal of conservative, supportive southern values. The collective result of all these demographic changes was an increasingly poor health profile for inner-city residents. And, some northern cities fared worse than others. In Washington, D.C. all of these demographic changes have been somewhat exaggerated because it was the first city to be more than 50 percent Black. This happened long before any other city achieved a 50 percent ratio. The result was the development of a large, concentrated, minority community which became increasingly isolated from other segments of society.

In an isolated, disadvantaged context maternal and infant health suffers. While maternity health programs will certainly be unable to remedy the results of large-scale demographic changes, there is an important lesson to be learned from an analysis of the demographic history of poor Black health. Maternity health care programs which encourage the integration of their clients into broad social institutions will create lasting benefits for the health of mothers and children. For this reason, it will be helpful to encourage the participation of entire families, including the conjugal partners of inner-city women, in their health care. My own research on Washington, D.C. women suggests that men may play a critical role in encouraging their partners to seek prenatal care. So, while all programs need to work with and be aware of reliance on the female network, every effort should be made to bring men back into the process of maintaining the good health of their partners and their children. The values exist among inner-city men which support this type of support--for they are very proud of the children they father--but so far the participation of men has not received broad programmatic support from health care workers.

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November 7, 1989

HAND-DELIVERED

The Hon. George Miller
Chair, Select Committee on
Children, Youth and Families
385 House Office Building Annex 2
Washington, D.C. 20515

Dear Chairman Miller:

We would like to submit the attached statement for the record of the hearing that the Select Committee held on "Caring for New Mothers: Pressing Problems, New Solutions," on October 24, 1989. The American Academy of Pediatrics first offered this statement in support of the Family and Medical Leave Act submitted for the record at joint hearings before the House Subcommittees on Labor-Management Relations and Labor Standards, held on February 25 and March 5, 1987.

The growing numbers of working mothers experience especially acute health care difficulties as they struggle to provide economic support for their families while attending to their own health needs and those of their new children. The Family and Medical Leave Act (H.R. 770) effectively responds to these mothers' needs by protecting their jobs when they require short-term leave to care for their own serious health conditions (including pregnancy and childbirth), as well as those of their children.

As further discussed in the attached statement, the Family and Medical Leave Act encourages the health, growth, and development of American families. We feel that its enactment is an important part of the effort to overcome barriers to effective maternity care and family health.

Sincerely,

Donna R. Lenhoff

Donna R. Lenhoff
Director for Legal
Policy and Programs

Enclosure
cc: American Academy of Pediatrics
DRL/ch

PREPARED STATEMENT OF ROSELYN EPPS, M.D., AMERICAN ACADEMY OF PEDIATRICS, WASHINGTON, DC, SUBMITTED BY DONNA R. LENHOFF, DIRECTOR FOR LEGAL POLICY AND PROGRAMS, WOMEN'S LEGAL DEFENSE FUND, WASHINGTON, DC

The American Academy of Pediatrics, an international organization representing more than 30,000 pediatricians specializing in the care of infants, children, adolescents and young people, has an active commitment to improving the health status of these patients and enhancing the quality of family life. We therefore support, in principle, efforts to promote job security for working families allowing parents to be with their children at critical parenting times.

The Academy recognizes the first few months of life as a significant period of growth and development for both the infant and the new parents. Infants are particularly vulnerable during this time, and require the active involvement of both parents in the nurturing process. The parenting skills that are acquired during this period are essential in the formation of a healthy parent-child relationship. Adoptive children and their parents also require several months to form physical as well as psychological attachments.

Another time when a child's physical and emotional well-being heavily depends on parental participation is during a serious illness. Children have increased dependency needs when they are sick, and require the unique warmth and security only their parents can offer. Allowing parents the option to care for and comfort their seriously ill child is sound pediatric practice.

Changes are occurring in the work force that have a major impact on families. As women enter the work force in increasing numbers, more and more infants are being born into homes where both parents work. A new addition to the family precipitates changes to which the family must adapt. During this period of adjustment, parents develop skills that enhance optimal physical and emotional growth of their child. Once parents and babies establish a solid attachment to each other, a smoother transition back to work is possible, and increased job satisfaction is likely. However, too few work places provide what we would consider adequate flexibility to allow workers to carry out their parenting responsibilities.

The stability and economic well-being of both families and employers are vitally important to our society. It is time to address the changing face of American work and family life with reasonable solutions that recognize the value of families while balancing the needs of employers.

We understand that the introduction of a national leave policy might require restructuring benefit packages and changing operational procedures. Nonetheless, the health, growth and development of American families warrant these efforts. With the input and cooperation of employees and employers representing a broad range of business interests, the goal of establishing a national parental leave policy can be achieved.

The importance of parental involvement in a child's development cannot be underestimated. As pediatricians and child developmental specialists, we support these efforts on behalf of children. We compliment Representative William Clay and Representative Patricia Schroeder on their efforts to design practical solutions to work/family issues that respect both employers and employees. Two-working parent families, as well as single parents who must work, are a constituency whose needs are still to be addressed. The demands of job and home must be balanced if we are to have excellent workers and competent parents.

Parents can work and have healthy families with our help. The need for stronger families in our society has been well documented. Let us begin to take steps to achieve this goal.

Prepared Statement of Dennis Williams, Assistant Director, NC Division of Medical Assistance and Marcia Roth, Special Assistant, for Planning and Program Development, NC Division of Maternal and Child Health, Raleigh, NC

Infant Mortality in the United States is a tragedy that has been well-documented since the early 1900's. Even though there were significant reductions in this rate during the 1960's and 70's, our country continues to lag behind other industrialized nations in the ability to save our most vulnerable citizens. The experience in North Carolina has largely mirrored the national experience. In our state, the development of a regionalized hospital-based system to care for medically high-risk women and infants, paralleled by rapid advances in medical technology, helped to save many lives. However, in the 1980's, North Carolina's infant mortality rate has stagnated.

Many health care experts believe that this stagnation is largely due to a lack of emphasis on prevention services and on our collective inability to commit the resources necessary for ensuring comprehensive services for pregnant women and infants. In light of the fact that we will always be faced with the constraint of having scarce resources and competing priorities for the use of public funds, we must be oriented toward what can be done with the resources at hand. With this perspective in mind, in 1987. North Carolina began to look at existing opportunities for more effectively organizing its health and human service programs in order to address the problem of infant mortality. As our elected officials were grappling with the larger issue of indigent health care and reviewing federal legislation, agency staff from Medicaid and Maternal and Child Health began to meet. Our intent was to address the nuts and bolts issues of improving access for comprehensive prenatal care in North Carolina, in anticipation of our General Assembly's adoption of SOBRA and COBRA. These discussions, spurred on by the legislative changes, and encouraged by a supportive administrative structure led to the implementation in 1987 of a multi-agency initiative called "Baby Love".

GOAL OF BABY LOVE

The goal of the Baby Love Program is to improve access to early, continuous and comprehensive health and support services for low income pregnant women and infants.

In order to achieve this, we realized the importance of recognizing the fact that indigent pregnant women face numerous obstacles in obtaining necessary care. When access to available services and programs is limited, clients may postpone or fail to enter the health care system at all. This in turn places them at risk for delivering low birthweight babies and experiencing the tragedy of an infant death or disability.

In addressing access barriers, one quickly comes to the conclusion that a single program or agency does not have the capacity to address these barriers in a comprehensive fashion. The only way to address the problem of infant mortality is to draw together the expertise of service delivery, health care financing agencies, and advocacy groups to develop a wide range of coordinated interventions.

BABY LOVE STRATEGIES - OPPORTUNITIES FOR IMPROVEMENT

A. Extended Medicaid Benefits to new populations of women and children

Many women of childbearing age have no health insurance or their insurance does not cover prenatal care. North Carolina's legislature created an Indigent Care Study Commission in 1985 to study "the issue of access to and financing of health care services for North Carolinians who are unable to pay for care". One of the Commission's recommendations that drew bipartisan support was to adopt OBRA-86 federal legislation. After the initial legislation that became effective in October 1987, additional action has been taken to:

1. Extend Medicaid coverage to pregnant women and infants (to age 1) up to 150% of the federal poverty level, effective 1/1/90.
2. Accelerate the incremental coverage of children, to immediately include children up to age 6 whose family incomes are below 100% of the federal poverty level effective 10/1/89.
3. Cover children up to age 7 beginning 10/1/90.

B. Developed a marketing strategy to encourage participation in public benefit programs.

Expanding the pool of potentially eligible clients does not mean individuals will know of the existence of available benefits or of the importance of good prenatal care. Furthermore, negative perceptions of Medicaid and historical linkages with welfare may deter clients from seeking medical assistance.

With these thoughts in mind, it was decided that we needed to develop a new message for the program, embodying a positive theme and portraying an image that is attractive to clients. To do this, 5 sets of brochures consisting of different logos, themes, and titles were tested through client interviews in local welfare offices and prenatal clinics. Clients overwhelmingly chose the name "Baby Love," the heart-shaped logo, and the use of a photograph of a pregnant woman over other available choices. Thus, the name "Baby Love" became the theme for Medicaid expansion and infant mortality reduction efforts. In North Carolina. Over time the name Baby Love began to symbolize public agency personnels' commitment to this endeavor. "Baby Love" serves as a marketing strategy for encouraging certain types of beliefs and behaviors on behalf of both service providers and clients. Three methods were used to "get the word out" about the availability of new benefits and the importance of prenatal care.

First, a broad brush public information campaign to announce the Baby Love Program was implemented. This involved the development and distribution of brochures and posters through an existing network of public and private service organizations to potentially eligible clients, publicizing a toll-free number that clients may use to obtain additional information about Baby Love, a direct mail campaign to pregnant women and their families who were participants in the WIC program, and special efforts to inform private sector health providers about Baby Love.

Second, local health departments and community and migrant health centers were recruited to be the focal point for a sustained "grass roots" effort to identify and encourage potentially eligible clients to seek prenatal care services.

Finally, to promote systematic participation of community organizations in efforts to reduce infant mortality, a database of local agencies who serve low income families was created.

- Initially 1200 agencies were sent special letters inviting their participation in the Baby Love Outreach campaign.
- Over 200 agencies are now contacted periodically about the Baby Love Program. They participate by referring potentially eligible clients to local public agencies.

C. Initiated reforms in the Medicaid eligibility process.

Beyond expanding Medicaid income levels and reaching out to potentially eligible clients, it was recognized that families are not able to negotiate the complex and confusing eligibility determination process. While program eligibility processes remain complicated, North Carolina's adoption of federal legislative changes has helped to make the system more "user friendly" and responsive to client needs. These new policies included:

1. Dropping the Asset Test
2. Providing continuous eligibility for the pregnant woman throughout pregnancy and the postpartum period
3. Providing automatic newborn eligibility.

Beyond the policy changes in the existing Medicaid program, the rules and procedures used to verify the clients' financial status were changed. These changes were designed to speed-up the process and make it more convenient to apply. As part of the implementation of Baby

Love, emphasis was placed on:

1. Implementing a new procedure called Presumptive Eligibility. For the first time selected prenatal clinics determine a pregnant woman's Medicaid eligibility for a temporary period.
2. Stationing Medicaid eligibility staff at selected prenatal clinic sites (such as Health Departments). So that potentially eligible clients can apply for Medicaid at the same location that they are receiving prenatal care.

In addition to internal system changes by those who determine eligibility, two other important steps were taken. First, through the development of a statewide system of Maternity Care Coordinators (Case Managers), clients can receive assistance in completing the Medicaid application process. The functions of the Maternity Care Coordinator and statewide care coordination system are discussed in the following section. Second, an administrative mechanism has been developed to systematically document and quantify the barriers encountered by low-income women who attempt to apply for Medicaid or obtain prenatal care services. This is a management tool that is used to more accurately evaluate access problems, and to serve as a catalyst for policy and program changes needed to meet program goals.

D. **Introduced a statewide system of Maternity Care Coordination (Case Management) to assist clients in obtaining comprehensive care.**

Developing outreach systems and reshaping eligibility processes are prudent investments if clients then receive compassionate, comprehensive, and continuous care. Traditionally this has not always been possible because fragmentation in the service delivery system has made it difficult to know of, find, and use appropriate service providers and programs. Some common problems experienced by clients include:

- lengthy waiting periods for entry to care;
- lack of transportation to and from the source of medical care;
- inconvenient clinic hours or long waiting times;
- lack of patient knowledge of the importance of prenatal care;
- lack of Medicaid coverage for certain medical expenses;
- lack of ancillary services and programs to assist women in meeting priority needs.

To address service delivery barriers, North Carolina's Baby Love Program created a statewide network of specially trained health care staff to assist indigent pregnant women to obtain medical benefits as well as other community services needed by them and their families. These are located in virtually all local health departments and in many rural health and community health centers. Maternity Care Coordinators provide ongoing support services essential to meeting the clients' comprehensive needs. This process includes the following:

- Outreach - Assisting potentially eligible clients to enroll in Medicaid, developing a strong referral network, and increasing community awareness of the benefits of services.
- Recruitment - Encouraging clients to seek prenatal care, offering full explanations of benefits, services and programs, and obtaining client agreement to work jointly toward

accomplishing the goal of comprehensive care.

- Assessment – Evaluating with the client the full range of needs, medical, financial, psycho-social, educational and nutritional.
- Service Planning
  - Identifying resources and interventions needed to ensure receipt of comprehensive care and agreeing on action steps to accomplish them.
- Coordination and Referral
  - Assisting clients in locating needed services, ensuring continuity of care is maintained throughout the pregnancy and postpartum period.
- Follow-up and Monitoring
  - Periodically assessing progress toward meeting patient and family goals.
- Education – Informing clients of the availability of childbirth and parenting classes and developing a supportive relationship.

In conjunction with the introduction of a care coordination system, the benefit package of covered services in Medicaid was enriched. This included reimbursement for prepared childbirth education and parenting classes, specialized in-home nursing care for medically complex pregnancies, in addition to adequate reimbursement for Maternity Care Coordination services.

E. Created a flexible interagency framework for administration.

Another feature of Baby Love is that Medicaid and Maternal and Child Health co-administer Baby Love and actively solicit the cooperation of other state agencies to more effectively develop the program. This, to date, has had an extremely positive effect because:

- policies and procedures developed reflect a joint health care delivery and health care financing perspective,
- there is direct input from local level agencies on all major policy issues; and
- there is consistency in addressing the day-to-day problems and concerns facing local agencies.

The Baby Love Program is based on the principle that infant mortality cannot be successfully overcome on a statewide basis by one agency or by one program alone. For the agencies and individuals involved, Baby Love symbolizes a new cooperative approach to program administration. Whether it is improving outreach, reshaping eligibility, coordinating service delivery, at either the state or local level, the challenge to the Baby Love worker is the same:

- Reach Out - You may be surprised at the positive response.
- Recruit - There are a lot of untapped resources available.
- Deliver - Do your part.
- Evaluate - Find out what's wrong and fix it. Do not fall into the trap of placing blame and looking towards others for solutions.

SUMMARY OF RESULTS

During the first 12 months of **BABY LOVE**, (from October, 1987 - October, 1988) 17,015 pregnant women, or 110 percent of the projected number of eligibles were actually enrolled in the expanded Medicaid program. Local health departments have begun to report decreases in "no-show rates" for clinics, increases in patient compliance, and ever increasing numbers of women participating in prepared childbirth and parenting classes. In addition, maternity care coordinators have been on the front line in addressing problems associated with poverty. The assistance of maternity care coordinators has enabled women to: secure needed transportation for clinic appointments; enroll in extended day school, GED and technical training programs; move to better, safe, affordable housing; obtain needed food, clothing and household furnishings; secure day care; resolve bad debt; reduce or cease substance abuse during pregnancy; and develop knowledge and skills necessary for self-advocacy and navigation of the health and human service delivery system.

The **BABY LOVE PROGRAM** has been designed to rigorously evaluate its effectiveness. A Pregnancy Outcome Report, which collects process and outcome data, is completed on every woman who receives maternity care coordination services and those women who receive prenatal care from local health departments, but do not participate in maternity care coordination.

Data for calendar year 1988 comparing women who received maternity care coordination to health department prenatal patients who did not receive care coordination reveal the following:

	WITH MATERNITY CARE COORDINATION	WITHOUT MATERNITY CARE COORDINATION	PROBABILITY OF THIS DIFFERENCE DUE TO CHANCE ALONE
1. Pregnancy Outcomes Resulting in a Live Birth	97.3%	94.3%	.001*
2. Live Births Less than 1500 grams	1.2%	1.8%	.004*
3. Live Births Less than 2500 grams	8.7%	10.2%	.003*
4. Women Making More than Eight Prenatal Visits	64.6%	53.9%	.001*
5. Women Receiving a Postpartum Exam	68.2%	38.8%	.001*
6. Infants Receiving Well-Child Care	64.2%	24.0%	.001*
7. Infants Receiving WIC	75.5%	34.6%	.001*

*=Difference is very significant. The probability that the observed difference was due only to chance is extremely low.

Among those women receiving maternity care coordination services, prenatal visits were substantially enhanced, participation in WIC was increased significantly, and their infants received more child health care. Most importantly, those mothers experienced reduced low birthweight and very low birthweight rates - (the most frequent cause of infant death and disability).

The data, however, does not convey the full impact that the Baby Love Program has had on the lives of low-income women and their families. This can best be understood by personal experience. The following example was received by one of our local health departments.

August 31, 1989

Dear Sir,

Well, here I was the mother of 2 little girls and very happy with the size of my family. I had no intentions of increasing the household and started working only one or two days per month for the past three years, and THEN it happened; I was pregnant with no health insurance for me or my baby on the way and only earning $75 to $100 per month. What in the world was I going to do? I knew I couldn't afford all the medical bills that would face me in the months ahead. I stayed pretty upset and cried a lot which was not good for me or my little baby growing inside. How was I going to get the care I needed and the baby needed for the next 9 months, and how would it pay for all those doctor visits he needed after he was born?

I decided to seek help at the county health department and soon learned that there was people here that cared about me and my baby, and they were eager and willing to help me any way they could. And help they did! The Maternity Care Coordinator asked me if I had heard of a program called "Baby Love". I told her no, so she tooked time out to explain how the program could benefit me and my baby. She told me to apply for the "Baby Love" program as soon as possible. She explained that if I was accepted and met the requirements, all my medical bills during my entire pregnancy such as visits to the clinic, medicine I needed, the delivery costs of my baby, his medicine, his delivery stay at the hospital, and all of his visits to the doctor after he was born; until he was three, would be **ALL COVERED**!! By this time I was smiling, she was smiling, and I felt a great burden of despair going away. I felt more at ease and relaxed than I had in quite a few weeks.

Finally, there was the help my baby and I needed. Right there at the county health department, through the "Baby Love" program. Even the title of the program is great, "Baby Love," because when you're an expectant mother, love is just what you and your baby need. This program took a heavy load off of my mind and turned all those worries I had into love for my baby.

Thank you Maternity Care Coordinator for being concerned enough to head up a "Baby Love" program for those of us in this county.

Thank you county government for the health department. My two girls, myself, and my new Baby Boy appreciate you being there for us.

Sincerely,